

DRUG ABUSE AMONG STUDENTS IN JAIPUR CITY

(With Particular Reference to Hostellers of the
University of Rajasthan and its Colleges)

THESIS

SUBMITTED TO

The University of Bundelkhand

FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

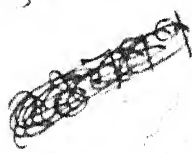
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1991

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C E R T I F I C A T E

This is to certify that Shri Ramesh Chandra Saxena, Head of Sociology Department, Agrawal College, University of Rajasthan, Jaipur, has conducted a research study in **"DRUG ABUSE AMONG UNIVERSITY AND COLLEGE STUDENTS (HOSTELLERS)"** under my guidance and supervision. The present thesis is the outcome of his study. He has very creditably accomplished the task. It is evident from a thorough-going and penetrating critical examination and analysis of various facts and issues bearing upon the problem of enquiry in which he has acquitted himself admirably.

Throughout the period of field work and subsequent data processing and their analysis he has done his work with utmost care, perseverance and demonstrable brilliance to my entire satisfaction. Mr. Saxena has uniquely succeeded in presenting an authentic delineation of the complex and socially anxiety-causing problem of drug abuse among students. His thesis contains a logical analysis, discussion of the pragmatic parameters of the problem, review of relevant sociological research literature, social policy and control in respect of drug abuse among the youth. Especially the hostellers, his diction is simple, impressive and quite succinct and style typically lucid. His thesis is reflective of a cautious, coordinated and integrated approach.

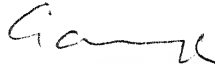
I believe this Ph.D. dissertation makes a refreshing, original and substantial contribution towards the advancement of recent sociological knowledge. I find this thesis to be of great importance to social researchers, younger generation, policy makers and administrators alike. It shall be of significant interest to the lay readers.

The candidate has worked for the period and in the manner prescribed under the rules of the Bundelkhand University.

I am happy to recommend his work for the award of the Ph. D. Degree by the University.

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A C K N O W L E D G E M E N T S

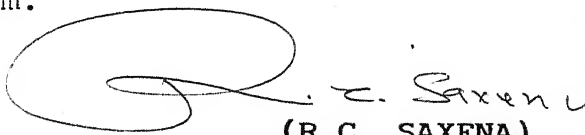
I am deeply indebted to my learned and gracious supervisor, Dr. (Mrs.) Gargi, Professor of Sociology and an Ex-Vice Chancellor of the University of Bundelkhand, Jhansi, without the inspiration, encouragement and the enlightened guidance of whose this dissertation would not have seen the light of the day. During the field work and consequent write-up of the report, I was fortunate enough to get the kind support, cooperation and guidance from a number of my teachers, colleagues and those who have some specialisation in research methodology or the problem of drug abuse and related fields. Not only sociologists have been consulted but eminent persons in the field of other social and medical disciplines have also been approached for their kind suggestions and critically evaluation of my efforts. I am deeply grateful to all of them. However, I shall fail in my duty if I do not acknowledge the kind and affectionate support as phylosophere frield and guide by Dr. Ram Ahuja, Dr. Kawal Ramani, Dr. O.P. Joshi, Dr. Ram Pal Singh Gaur, Dr. Shiv Gautam. I am also indebted to what my eminent professor, Dr. S.P. Nagendra, the Ex-Vice Chancellor of Lucknow University, who in my student days

was kind enough to give me all sorts of emotional and intellectual support, and invivoration. Though he has not contributed directly to the preparation of this thesis I am really grateful to him for his initial encouragement and inspiration.

This thesis took more than three years for its successful final. During this period my wife Smt. Kusham Saxena and my children Aradhana and Ashutosh have patiently and without little murmur or any botheration to me have borne the difficulties caused by my single minded devotion to this work. I need express a word of apology to their patient for-bea-rance.

The most important is the role of those who were subject of enquiry and others who prompted and motivated them to cooperate sincerely with my efforts which cost them much discomfort and loss of time. I am very very deeply thankful to them all. My gratitutde to Mr. Ramesh prakash Bohra, Mr. Meherchand and Mr. Jai Kishan Vachhani of M/s. Kamaldeep Commercial Institute, Jaipur, who have been very liberal and inextinging their full cooperation to the preparation of the final manuscript and this dissertation in the present form.

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P R E F A C E

This dissertation is intended for all persons interested in examining high use, high abuse drugs in India and the impact these have on individuals (especially younger generation) and on society. When published, it can be used by health and drug education classes, public health courses, parent groups, and counselor training. It covers every major street and recreational drug, and many of the prescripts and over-the-counter drug that has a history of abuse or misuse. In addition, many of the drugs (psychotropic substances - genuine or spurious) promoted in quackery in this country are discussed with particular reference their impact on the younger population and their implication for society. Of course, the emphasis is not on clinical aspect of drug abuse/misuse. The approach is that of a sociologist. Criminologists, law enforcement authorities, and health professionals can also use it to their advantage.

This dissertation provides facts about drug sources, history, action in the body and mind, side-effect, interactions, tolerance, abuse potential, dosage, dependency, drug delivery systems, and alternatives to drugs in use today. Students and the youth in general appear eager to discuss the impact of drugs on

their lives. This thesis provides a host of golden opportunities. Consider the Prologue (An Introduction to the Problem under Study' - Chapter I), which contains such wide ranging topics as history of the drug abuse problem among students, and Indian population, in general ; the social phenomenon of drug abuse, review of research and other literature on drug use/abuse/misuse ; critical appraisal of the National Survey (also repeat survey) during a decade (1976-860 on drug Abuse among College/ University Students of Seven metropolitan cities - Delhi, Jaipur, Bangalore, Bombay, Lucknow, Hyderabad and Saugor - and basic concepts relating to drug abuse/misue ; classification of abusable (misusable) drugs etc.

The Introductory Chapter I also discuss in detail the objectives of the study, research design, methods and products, tools and techniques, hypotheses and the overall plan adopted for the analysis and generalisation of the data collected through field work.

Chapter II (Approaching the Problem) is sub-divided into a number of sections. This chapter contains a critical appreciation of earlier studies and methodology. Its sectional discussion encompasses psycho-social aspects of drug abuse ; analytical studies ; questions to answer ; thematic dimensions ; reasons for the choice of the problem ; design of research ; the

The Chapter III contents are based on the data collected through field work. We have discussed in depth the incidence, pattern and socio-economic-cultural etc. background of drug use among students (particularly, the hostelers in Jaipur city) the educational background/performance/achievement in academic field including association with the type of schooling ; economic status and life style of the drug-users family (extended family and the peer group - not overlooking the life style promoted traditionally in the hostel/lodge drug using students reside in ; nature and frequency plus quantity of drug consumed and the method of administration/comsumption of drugs.

Chapter IV deals with the socio-cultural-economic variables of drug users/abusers/misusers, such as age, sex, marital status, education, class (with year, schooling, faculty), academic interest, economic status of the drug users' family with its life style ; residential background and duration of stay in Jaipur city ; religious-spiritual inclination or otherwise, language spoken ; sources of getting drugs have also been discussed. A finalies to the dicussion underlines the dangerous implications for human health, particularly for the adolescent and youth population which is the base of national citizen.

The fifth chapter deals with the "motivations for drug use. It encompasses such vital issues as initiation to drug use ; source of first suggestion ; place and drug of first use, conditions promoting drug abuse leading to addiction/dependence ; reasons for abstinence. The typology of drug abusers has been formulated keeping in view the earlier formulations. The problems emanating from drug us/abuse/misuse have been analysed in depth, for an acquaintance with such problems can only serve (?) as warning posts (or signals) to those who use drug/s against their will/or their wish and kin and other sympathisers. An adequate answer has been sought to the over-poignant and anxious question. "Does prior knowledge serve as a deterrent to drug use. Another important aspect of the problem of drug abuse, namely, the post effect reactions and their consequent fate. Time of drug use and post-effect activity analysis makes an interesting and revealing reading. Finally, the withdrawal syndrome or the conditions situations/bodily and mental reactions pertaining to abstinence from drug use (especially after falling prey to dependence) has been elaborately examined.

The Sixth Chapter analyses the role of the family and the peer group in drug usage. A number of important sub-variables (constituent ones) such as staying away from

family, family organisation, inter-parental relationship, family structure and composition ; parent-children relationship ; size of the family ; upbringing of children relationship patterns ; including family control, birth order of drug abusers ; parents' awareness of children's drug use ; and parental role especially their guidance, supervision and disciplinary role.

Chapter seven analyses the very crucial aspect of drug use/abuse/misuse in the sense what role knowledge of drugs and formation of perceptual images play in the dreaded and much despised phenomenon of drug abuse in its different facts. Herein we have discussed in some length such issues as drug knowledge ; motives in drug taking ; attitudes towards drug abuse. Then it has been sought to emphasize that drug use is a form of learned behaviour as all other activities, normal or abnormal, are established to be the quintessence of human personality. Lastly, we have taken pains to formulate a paradigm to explain drug abuse on socio-cultural parameters.

The last chapter (VIII) deals with conclusions, suggested improvement in drug research policies and procedure and the societal concern for a pragmatic policy of control on drug consumption, both on the macro as well

as the micro levels. A synopsis of this chapter includes section on the discussion (often critical yet pragmatic) on the problems of effects of drugs ; reactions of de-drugged/de-drugging persons ; the programme for treatment and rehabilitation detailing various prevalent or future (projected) procedures and institutional settings. Due emphasis has been laid on the prevention of drug abuse/misuse keeping in view the difficulties and snags involved in the implementation of a restrictive or control policy including the fad of so-called unpragmatic social therapists. Suggestions for new research orientations and quest for more pragmatic and effective procedures of control in all forms of drug abuse and agencies and systems leading to the deterioration of the problem of drug menace have also been hazarded. Finally, various facts of prevalent and to be adopted policy for drug control have been delineated in some detail keeping in view what has to date occurred on the drug scene in some of the most advanced countries of the world. Indications about the ineptness and failures/shortcoming of the national policy in India relating to the drug problem have also been attempted.

Thus, the panorama, it be so called, of the drug scene in our college/university hostels within the overall complex and variegated scenario on the national front has been sought to be intelligently surveyed. How far, we have succeeded in our modest effort is subject to the opinion and assessment of our learned readers. And the last world, I for myself, am a strict non-drug user. Only my sympathetic and empathetic relationship with the hostelers under scrutiny, in various capacities and moods, has impelled and encouraged me to present the humble and micro-level study in this dissertation form. May I pray the Almighty to give me that peace of mind and contentment which usually follow an honest and faithful academic endeavour.

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CHAPTER - I

PROLOGUE : THE PROBLEM

CHAPTER - I

THE PROBLEM

1. INTRODUCTION

Drug abuse is rapidly gaining ground over the world. A UN survey for 1990¹, reported that drug abuse and trafficking lessened in some developed countries but grew alarmingly in many other parts of the world. The Third World also showed big spurt in drug abuse and trafficking. Compiled by the International Narcotics Control Board, the study noted trends in different regions of the world, suggesting a drop in over all drug abuse in East Europe and of crack cocaine in North America. Drug abuse rose in South Asian countries including India, Bangladesh, Nepal, Srilanka and Pakistan. India's major cities showed increasing trends in drug abuse. According to the survey, Nepal remained a major producer of cannabis and cannabis resin much of which ended up in India. Srilanka continued to serve as a transit country for heroin from India to the West.

In the seventies it was officially reported that drug abuse in India was limited except alcohol and tobacco. However, some disturbing signs were noted which indicated deterioration in drug abuse scene. One of the recent developments taking place in this area is the

1. The Indian Express, New Delhi, 10.1.91.

addition of heroin to street drugs. This has complicated further the problem, because it is almost impossible to eradicate hard drugs like heroin from any area where they have firmly established. Deaddiction clinics in major cities of the country and 'huge hauls' of contraband drugs by enforcement agencies after encounters with smugglers and drug traffickers speak volumes of the enormity of the problem.

Located between the 'Golden Crescent' and the 'Golden Triangle' and due to its vicinity with Nepal India has now achieved the dubious distinction of being the largest transshipment centre for drug trafficking in the world². India's porous border with Nepal has only aggravated the situation within the country as Nepal remains a major source of cannabis and cannabis resin.

Heroin, hahish (charas), marijuana (Ganja), opium, cocaine, morphine and methaqualone (mandrax) flow in through the entry points located on the country's international borders with Pakistan, Burma and Nepal.

2. Bhim Sain, **Drug Danger & Social Behaviour**, p. XVI.

The 3,110 km long Indo-Pak border facilitates the trafficking of opiates and cannabis resin (hashish) into the country from Afghanistan and Pakistan which together with Iran form the Golden Crescent. Owing to its proximity to the Lahore-Kabul highway, Jammu and Kashmir remains vulnerable. Till recently the border along Punjab was dotted with numerous entry points. With the tightening of security along the Punjab border, primarily to check the infiltration of terrorists and partly to counter the narcotic threat, traffickers shifted to a relatively safer zone - Rajasthan. The Rajasthan sector has now become a traffickers' paradise.

India's transit points are fast becoming the consuming ends. Heroin and hashish are in great demand in the metropolitan cities and satellite towns. Delhi alone has 1,00,000 people who are either traffickers, pedlars, street pushers or addicts. The rot of drug addiction has penetrated into our society. The statistics presented at a seminar on drug addiction in Calcutta (March, 1988)³ revealed that drug addiction claims more than five lives a day in Bombay city. The menace in Calcutta has assumed a serious proportion with an estimated 50,000 persons falling prey to deadly habit every year. According to an estimate, there are more than twenty lakh drug addicts in the country.

3. Bhim Sain, *Drug Danger & Social Behaviour*, p.XVI.

Perhaps the worst aspect of the drug menace is that it makes its deepest impression on the adolescents and youths who are most vulnerable. The use of drugs has a strong appeal for those who are beginning their struggle for independence as they search for self-identity. The younger people have innate curiosity and thirst for new experiences. So they are particularly susceptible to drug experience. Future generations of people are being contaminated by this scourge. When a substantial percentage of any generation is victim to an addiction, it loses contributing good citizens and acquires a crippling social burden. The insidious spread of drug addiction in the younger generation of Indian society, particularly student community, assumes the most horrifying aspect of the problem.

Drug abuse has deep impact on individuals and on society. Owing to wide and extensive prevalence of drug culture man and society are facing a gloomy future. A broad overview of the use of drugs and their implications for society is an imperative need of the present time. Unless the horrendous consequences of the drug abuse are studied and understood here and now. The people of India in general, and the younger generation in particular, will full victim in increasing numbers to this dreadful malady. The youth

have always been the backbone of every society and of its well being and security and, therefore, it could not be exposed to this growing menace.

India is passing through a phase of rapid social and economic changes. Some of the conditions, which have contributed to the development of serious type of drug abuse in advanced countries, are being replicated here. During the last fifty or so years India has been moving fast in the various social processes such as industrialisation, urbanisation and modernisation. With the spread of education, particularly higher education and development of science and technology our whole way of life and style have undergone a sea difference. Our educated elites have adopted the western way of life and style. It is no surprise, therefore, that the western trends, very commonly observed in the industrialized modern societies, should be manifested in our urban populations.

2. DRUG ABUSE : AN OLD SOCIAL PHENOMENON

The use of drugs of one kind or the other is not a new social and cultural phenomenon in this country. The use of traditional psychotropic substances, such as cannabis and opium, among various castes, tribes and communities of great Indian culture, has been very common since ancient times. Indians have had the knowledge and acceptance of hallucinogenic substances in socio-religious

Drug addiction, a cultivated craving for the use of drugs, is one of the oldest phenomena. The societies all over the world have been using psychoactive drugs and intoxicants extracted from more than 4000 plants and flowers to cure various kinds of human disease. From times immemorial there are people who take the drugs on their own, outside of medical advice, mainly for pleasure or to avoid or decrease pain, discomfort or frustration. Besides, therapeutic and hedonistic considerations and need for escaping from the reality of life's stresses and strains have been primary motivational factors of drug abuse. In many cultures, drugs also become valuable adjuncts of socio-religious rituals. Use of psychotropic substances in various phases of life was accepted in many societies and probably did not cause any concern or create any social problem till the middle of twentieth century.

However, over the past two or three decades there has been unprecedented spread of the use of illegal drugs in all parts of the world. No nation has been immune to this devastating problem. Its nature and severity may differ to a great extent in different regions/countries. With growth and advancement of modern science and technology an increasing

number of alkaloids and drugs extracted and prepared from them, such as heroin, hashish and smack, have caught the fancy of youth and assumed the form of a youth sub-culture. In fact, no section of society has been left without deep scars of drug menace.

The drug abuse among students in secondary Schools, Colleges and Universities in India has recently assumed more serious proportions. Indian youth already influenced by Western culture, specially Beatle and Hippy culture, openly welcomed the drug invasion by smugglers and street pedlars. Along with other drugs heroin epidemic spread very fastly among the youth. In fact, it is this phenomenon that is largely responsible for widespread attention which the drug problem has begun to receive at present.

3. REVIEW OF LITERATURE

Several groups of workers have studied the pattern of drug abuse in the University students. Banerji⁴ studied drug abuse among Calcutta University students and found that the prevalence rate of drug abuse was 17.4 per cent out of which 11.4 per cent abused amphetamines.

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4. Banerjee, R.M. (1963), 'Prevalence of Habit Forming Drugs and Smoking Among the College Students : A Survey, **Indian Medical Journal**, 57, 194.

reported that the prevalence rate of drug abuse (without medical prescription and excluding alcohol and tobacco) was 25.1%. They also studied prevalence of drug abuse in the University students (Sethi and Manchanda). Dube and Deb found an overall ever used prevalence rate of 56.2 per cent and 29.6 per cent respectively. Bhadra¹¹ reported drug abuse as 19 per cent along with alcohol.

Most of the above mentioned studies after from some limitations and are really not comparable, because of the following reasons :

- (1) Improper or different sampling procedures have been adopted.
 - (2) Drugs included vary : Some of these studies have included alcohol, tobacco and painkillers while others have not.
 - (3) Definitions of drug users/abusers vary.
 - (4) Non-response rates in most of these studies have not been mentioned.
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Dayal⁵ reported that 5 per cent of Delhi University students were current drug users (on regular basis or dependent). Mohan and Arora⁶ in a sample survey of Delhi University students showed an overall prevalence rate of 30.1 per cent for drug abuse (including alcohol and tobacco). Chitnis⁷ in Bombay University, and Varma et. al.⁸ in Punjab University, Chandigarh found the prevalence rate of abuse as 19.7 per cent and 19.9 per cent respectively. Mohan⁹ in a pilot survey of Delhi University students found that the overall prevalence rate of drug abuse (without medical prescription and excluding alcohol and tobacco) was 32.7 per cent. Sethi and Manchanda¹⁰ in a study of medical students in Lucknow

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5. Dayal, J. (1972), "Drug Abuse and Youth", Inter Disciplinary Seminar, Directorate of Social Welfare, Disciplinary Seminar, Directorate of Social Welfare,
 6. Mohan, D and Arora, A. (1976) "Prevalence and pattern of drug abuse among Delhi University College students", **Journal of Indian Medical Association**, 66, 28.
 7. Chitnis, S. (1974), **Drug abuse on college campus**, Tata School of Social Sciences, Bombay.
 8. Varma, V.K. etc. (1977), "Drug Abuse Among College Students", **Indian Journal of Psychiatry**, 19 (1)1.
 9. Mohan, D. Sundaram, et. al. (1981), Paper in **Current Research in Drug Abuse in India**, Gemini Printers, Delhi, pp. 18-31.
 10. Sethi, B.B. and Manchanda, R. (1977), Drug Abuse Among Medical Students, **Indian Journal of Psychiatry**, 19(4), 31.

Though a few Indian psychiatrists and medical scientists in late sixties and early seventies made some observations on the problem of drug use and drug dependence, yet sociologists lacked interest in the subject. Sociologists and social scientists conducted several researches in various forms of deviant behaviours in the last four decades yet drug consumption as a field of deviant behaviour has remained completely neglected. They realised rather late that it was their academic responsibility to understanding the nature of drug abuse problem and its prevalence in our society. Analysing the sociological assumptions underlying the drug usage and developing a general theory or a system of propositions, that should account for drug dependence and the particular processes of drug addiction, should have been their important concern.

Some attempts in their fields have been made by Western sociologists¹², but their approaches according to R. Ahuja, have come to be questioned by radical thinkers and activities.¹³

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12. (1) Alfred R. Lindesmith, **Opiate Addiction**, Principia Press, Bloomington, 1947. See also his "A Sociological Theory of Drug Addiction", **Americal Journal of Sociology**, 43 (1938) pp. 593-613 and "The Drug Addict as Psychopath", **American Sociological Review** S. (940), p. 920.
- (2) Joel, Fort, **The Pleasure Seekers : The Drug Crisis, Youth and Society**, Indianapolis, Bobbs - Merrill, 1969.

It is, therefore, necessary to evolve a new paradigm and a new theory pertaining to drug abuse problem in socio-cultural context of India. Sociologists and social scientists engaged in analysing drug behaviour should explore the possibility of such an approach and the method to approach it closely.

4. NATIONAL SURVEYS ON DRUG ABUSE AMONG UNIVERSITY STUDENTS

The Department of Social Welfare, Govt. of India, sponsored in 1976 a national survey on drug prevalence on a representative basis, at seven metropolitan and non-metropolitan centres - Bombay, Delhi, Hyderabad, Jaipur, Sagar, Madras and Varanasi. The report of the Repeat Survey', 1986 could not be available. The objectives of this survey were as follows :

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12. (3) Maurer, David and Vogel Victor, **Narcotics and Narcotic Addiction**, Springfield Charles C. Thomas, 1967.
 - (4) Blachly, Paul H. **Drug Abuse**, Charles C. Thomas, Illinois, USA, 1970.
 - (5) Jock Young, **The Drugtakers : The Social Meaning of Drug Use**, Mac Gibbon and Kee, London, 1971. See also his articles "Drug use as problem solving behaviour." in **Proceedings of the Anglo-American Conference on Drug Abuse**, Royal Society of Medicine, London, 1973.
 - (6) Jameo L. Carey, **The College Drug Scene**, Englewood Cliffs, Prentice Hall, 1968.
 - (7) Reginald G. Smart, "Drug use among High School Students, In **Drug Abuse** by Paul H. Blachly, op. cit. pp. 153-168.
 13. R. Ahuja, **Sociology of Youth Sub-Culture**, p.4
 14. R. Ahuja, **Sociology of Youth Sub Culture**, p.4

1. To determine the pattern and prevalence of drug abuse among college and university students in selected cities in India.
2. To understand the sociological and psychological determinants of drug abuse and,
3. To suggest certain remedial measures to reduce the incidence of drug abuse.

The preliminary results of the national survey have been included in a book entitled "Current Research in Drug Abuse in India" by D. Mohan., H.S. Sethi and E. Tongue. The universe of this study were all the college students at undergraduate and postgraduate levels (excluding evening college and correspondence course students) in the selected cities. The sample size to be covered in the study was about 4200 at each centre. Uniform tools for the study and the same operational definitions were adopted. The results included (1) Percentage prevalence, (2) Percentage prevalence rate of drugs at various centres, (3) Percentage prevalence rate of drugs according to (i) sex, (ii) type of drug groups in different combinations, (iii) the type of drug use and sex and (4) Percentage prevalence rate of current users.

The survey significantly revealed at least one (feature, which was different from all the previous studies, except those which had measured life time use. The prevalence rate of all drugs except tobacco, alcohol and painkillers was far below the earlier figures cited. The drugs which are of concern to the international, national community i.e. psychotropics, opiates, cannabis, LSD were being used by much smaller percentages than talked about or estimated earlier.

Cannabis use was the only one which was observed in 10.9 per cent of the respondents at Varanasi and 8.4 per cent at Sagar. In all other centres it remained around or below one per cent. For almost all of the drugs the prevalence rates were remarkably higher among the males as compared to females. The tranquiliser rates were below 5 per cent higher in males and lower in females. It appeared from the survey data that drug abuse did not present a major problem among college students in metropolitan or non-metropolitan cities.

The use rate was comparatively higher in the residential university such as Varanasi which strongly suggested that probably staying away from home contributed

to increased drug use. This is an observation which has been suggested by some earlier studies also (Mohan & Arora, 1976, Mohan et. al. 1977, Mohan et. al. 1979). This would have to be verified from other studies to see if the students staying in hostels took drugs more than the non-hostelers, whether due to easier availability, loosening of parental control and peer group pressures, singly or jointly, contribute to its intake.

The highest prevalence rates were observed for alcohol, tobacco and painkillers in different centres. They were usually higher for boys, compared to girls. 8.5 per cent girls in Bombay took alcohol whereas in other centres the percentage ranges around two. Tobacco consumption was also found to be increasing among women, though the percentage remained around one.

In all the centres surveyed, the percentage of never users of all drugs taken together including alcohol and tobacco, was well over fifty.

If tobacco and alcohol combination was also included, the percentage of non-users was as high as ninety per cent in Madras, to as low as sixty per cent in Delhi. Tobacco and alcohol formed the commonest combination used and it provided the base for experimentation with any other

drug in combination with them. The single drug abuse figures were high, because of probable inclusion of painkillers. Even in painkillers abuse Madras and Jaipur as cities came out last. It is remarkable because either the physician compliance is very high in these cities or drug control is more strict or that respondents by tradition are abstainers, while the process of modernisation with its antecedent tensions escapes them. Above 90 per cent girls in Madras and Jaipur were abstainers while in Bombay they were sixty per cent. These percentages were higher as compared to boys. However, painkillers were consumed by higher percentage of girls as compared to boys, which probably related to their use during menstrual cycle.

Summarising, on superficial analysis the multicentred study revealed that (1) the use of drugs other than alcohol and tobacco and painkillers was low. (2) It was much more common among boys, compared to girls, though they were beginning to breakdown traditions. (3) The use of dangerous drugs, such as cannabis and tranquillisers, showed up commonly but there is no opiate use on any large scale. (4) It suggested the possibility that drug education programmes should concentrate with tobacco and alcohol rather than other drugs, for two reasons : their known demonstrable health hazards and their breaking the barrier between the user and the non-user state.

The national empirical investigation on drug prevalence was a collaborative representative psychosocial study which aimed to explore the emerging nature and pattern of drug consumption in a selected population of college and university students, assuming that this group is the most vulnerable one to drug abuse. The study presents (1) a common and tight-knit orientation of the problem of drug abuse among college students and (2) identifies a few hypotheses of sociological relevance of a fairly wide scope.

Dr. Ram Ahuja, one of the project directors of this study, was responsible for the completion of study of university students in Jaipur city. According to him the study deals mainly with three problems : nature and extent of drug use, etiology of the drug use, and strategies in societal action. According to him, the use of drugs raises three fundamental interpretations. One group interpretes it as an anti-social behaviour calling for suppressive measures against the 'criminal' users. The second group views the issue as one of personal maladjustment by troubled individuals requiring medical or psychological intervention. The third group focusses attention on the malfunctioning of social and cultural systems that produce frustrations and

lead to the use of intoxicants. Analysing different theoretical approaches used in explaining drug addiction, this research outlines a new theoretical framework for understanding of the deviant drug behaviour. Dr. Ahuja calls it a problem qualifying as one of the forms of 'deviant behaviour without victims.'

In this view, drug abuse can be studied both as a deviant behaviour and as a social problem. In the former sense it is to be regarded as an individual's social maladjustment. And in the latter sense it is to be viewed as a widespread condition that has harmful consequences for society. Unlike several western countries, where drug abuse is considered a social problem, in India, though regarded as a problem, it is not yet considered a social problem. This is because people in India do not consider the prevalence of drug abuse to be so widespread as to cause them a grave concern for some ameliorative action.

5. THE HYPOTHESES

From the various studies conducted in India on the use of drugs during the last two decades some hypotheses pertaining to drug use were derived. For purposes of our study following hypotheses were drawn up for testing :

1. Affluent students tend to experiment with drugs more than those who come from lower socio-economic strata of society.
2. Students with professional courses show a higher tendency for drug use than students with non-professional courses.
3. The rise of drugs seldom varies with the class of study (undergraduate and post-graduate).
4. Nature of drugs used varies with sex.
5. Nature of drugs used varies with the income group.
6. Students under greater degree of parental/control are less likely to take drugs.
7. The more distant the youth feel to their parents, the more likely they are to take drugs.
8. Drug users are economically as much dependent on their families as non-users. That is, drug taking students seldom try to supplement their income by engaging themselves in part-time jobs.
9. Participation in peer groups taking drugs tends to motivate youth more easily and more often to use drugs.

10. The more the students participate in alternative co-curricular and extra-curricular activities, the less likely they are to take drugs.

11. *Drug taking behaviour of students varies with their academic performance at college/university

6. OBJECTS OF THE PRESENT STUDY

The present study is rather limited in scope in the sense that it seeks to study the drug abuse among college and university hostelers in Jaipur city. Dr. Ahuja's first study covered college and university students, both resident and non-resident, about twelve years ago. It was repeated in 1986. Another sociological study of drug abuse among Indian youth by Tribhuwan Kapoor throws interesting light on some aspects of the problems under our investigation.¹⁵ The main objectives of our study are :

1. To determine the nature, pattern and prevalence of drug abuse among the students.
2. To analyse the nature and extent of prevalence of drug abuse according to the abusers' socio-demographic characteristics.
3. To determine the association of drug abuse with the personality or psychosocial behaviour of the users.

15. Tribhuwan Kapoor, **Drug Epidemic Among Indian Youth**, Mittal Publication, Delhi - 1985.

4. To study indepth correlations of various personality, family, parental and peer group interactions facilitating or inhibiting drug abuse.
5. To suggest measures for controlling the misuse of drugs.

In brief, the present study deals with five aspects of the drug problem. It analyses processes of initiation and induction of potential youth to drug abuse, examines "causes" of drug usage, presents a systematic theoretical approach to understanding drug behaviour and suggests measures for ameliorative action on the drug scene.

7. BASIC CONCEPTS

Before analysing various aspects of drug usage, it would be appropriate to define precisely and understand certain basic concepts in drug abuse terminology.

DRUG

'Drug' is a chemical substance associated with distinct physical and/or psychological effects. From a pharmacological or legal viewpoint, a drug is any substance which chemically alters the structure or function of a living organism. But this definition is broad enough to

encompass everything from vitamin to laxatives. It is, therefore, of little practical value. Medically speaking, a drug is any substance prescribed by a physician or manufactured expressly for the purpose of relieving pain or for diagnosing, treating and preventing any disease or disorder. Here the reference is to **ethical drugs**¹⁶, which are advertised and promoted mainly to physicians, pharmacists and allied professionals, usually requiring a doctor's prescription. Drugs sold by chemists directly to the public not requiring a prescription (i.e. Vicks Vaporub, Aspro, Phosphomin, Iodex etc.) are known as **proprietary/over-the-counter drugs**. Over-the-counter drugs also include Ganja, bhang, charas, alcohol etc. which are publically sold by the licenced vendors at their shop-counters.

Medicinal drugs of modern Allopathic Therapy are sold in finished forms such as capsules, tablets, syrups, powders, granules and injectables etc.

The general belief that all drugs have some intrinsic property that automatically classifies them as

16. Harivanch Chaturvedi, **Drug Industry, Social Responsibility and the Multinationals**, Commonwealth Publishers, New Delhi, 1990, p.7

drugs or the experts' assumption that the category 'drug' is based on a natural pharmacological reality (something as part of a natural, organic and chemical entity) do not furnish an adequate definition of a drug. No formal, objective characteristics of chemical agents will satisfy both criteria of an adequate definition simultaneously. There is no effect that is common to all "drugs" and that at the same time is not shared by "non-drugs". Some drugs are powerful psychoactive agents - they influence how the mind works, others have little or no impact on mental processes. some drugs have medicinal properties ; others have no medical value at all. Some drugs are toxic - they require very small amounts to kill living beings. Other drugs build tolerance very rapidly. Increasingly higher doses are required to achieve a constant effect. Others do so slowly or not at all. Some drugs are "addicting" - they produce a physical dependence, others are not. There is no conceivable characteristic that applies to all substances considered drugs.¹⁷

Turning to the social definition, we find that the concept "drug" is a cultural artifact, a social fabrication. A drug is something which has been arbitrarily defined by

17. Erich Goode, **Drugs in American Society**, Alfred A. Knopf Inc. New York, 1972. p.18.

certain segments of society as a drug. The effects of different drugs have relatively little to do with this definition. But it is no less real because it is arbitrary. Society defines what a drug is, and the social definition shapes our attitudes toward the class of substances so described. Nothing is a drug according to some abstract formal definition, but only within certain behavioural and social contexts. Therefore, when any one speaks or writes of drugs, whether layman or professional, physician, sociologist, journalist, or politician, he is referring to a **social and linguistic** category of entities, not a natural or pharmacological category.¹⁸

When we look at drugs in a generalised and comprehensive way, we find that it is not so much the substance of a material that makes it a drug, but rather some particular social definition.¹⁹ In broader sense, the term is applied to the whole range of mild-altering drugs, including aspirin and antibiotics etc.

In the psychological and sociological contexts, drug is a term for habit-forming substance which directly affects the brain or nervous system. More precisely, it refers to

18. Ibid. p. 19

19. Barber, Bernard, **Drugs and Society**, New York, Russel Sage Foundation, 1967, p. 2.

any chemical substance which affects bodily function, mood, perception or consciousness, which has potential for misuse and which may be harmful to the individual or society²⁰. In terms of this last definition, the frequent use of drug is considered so dangerous and immoral that it aroused a variety in indignant and hostile sentiments on the part of the general public.²¹

Some drugs are, however, relatively innocuous. They are not addictive ; their use does not result in harmful physiological effects ; and they do not produce exaggerated behaviour. Use of such drugs stands in marked contrast to tobacco smoking and alcohol consumption. Both of them are associated with distinctly harmful physical effects on the users. Yet, because of socio-cultural considerations, consumption of alcohol and tobacco is not illegal though society seeks to discourage the "vices" of alcoholism and nicotnic-habituatation.

For the purpose of the present study the following drugs are included :

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20. Joseph Jullian, **Social Problems**, Prentice Hall Inc. Englewood Cliffs, New Jersey, 1977.
21. R. Ahuja, **Sociology of Youth Sub-Culture**, Rawat Publications, Jaipur, 1982, p.5

1. Alcohol : Bear, wine, hard liquor.
2. Amphetamines : Purple hearts, speed, methylamphetamines, Dexedrine, Ritalin, Methedrine.
3. Barbiturates : Sedatives, Seconal, Mandrax, Downers.
4. Cannabis : Marijuana, Charas, Bhang, Hashish, Pot, Shit.
5. L.S.D. : Psychedelics, Hallucinogens, Acid.
6. Opium : Goli, Morphine, Heroin
7. Cocaine :
8. Pethidine :
9. Painkillers : Asprin, Anacin, APC, Codeine.
10. Tranquillisers : Equilibrium, Equanil, Librium, Calmpose.
11. Tobacco : In the form of cigarettes, cigars, pipe, bidis etc. and in the form of eatables.

DRUG ABUSE

Physicians commonly employ the term "abuse" to refer to the use of a drug outside a medical context. The term, however, conveys a moral rather than a scientific judgement. "Abuse" clearly connotes something negative or bad. But it should be noted that non-medical drug use is not invariably harmful. The non-medical taking of drugs, actually, only certain types of drugs, is undesirable, that the benefits obtained from illegal drugs are counterfeit and that they are capable of causing medical damage. However, we must not, under ideological assumptions, see only the "abusive" aspects in a drug. Sufficient data must be collected to "demonstrate" the damages of non-medical drug use. The harmful effects of non-medical use of a drug needs close investigation.²²

Deviant drug-oriented or drug-using behaviour refers to illegitimate use of any one of the natural or synthetic drugs. 'Drug abuse' means both the misuse of legal drugs and the use of illicit drugs. For our purpose, 'drug abuse' can be defined as the use of unacceptable drugs so that physical or psychological harm can result.²³ The "drug abuse" includes smoking 'pot' (hashish or ganja or marijuana),

22. Erich Goode, op. cited, p. 27.

23. We have largely followed Dr. R. Ahuja on this point.

taking a 'pep pill' (amphetamines), being high on 'speed' or 'trip' (taking L.S.D.), snuffing heroin, injecting morphine, getting 'kiks' (taking intravenous injection of Methedrine) and so forth. 'Drug abuse' will, therefore, be operationally defined as non-medical use of unacceptable drugs.

It has been discovered that abuse of legal drugs causes more harm than the use of illegal drugs. Of the widely abused legal drugs those requiring a doctor's prescription are potentially more harmful and cause a more serious problem than those obtainable without a prescription (e.g. Aspirin, Calmpose etc.) Many physicians ignore or are unaware of the side effects of legal drugs. Sometimes the consequences of overprescribed or overused drugs are more disturbing. Overuse of tranquillisers, amphetamines and barbiturates are the examples of legal drug abuse. Three main reasons can be ascribed for abusing both legal and illegal drugs : (i) easy availability of drugs, (ii) persistent advertising and other sales promotional efforts by drug producing companies, and (iii) the common and popular desire for convenient, short-term solutions to problems or instant cures for symptoms or difficulties.²⁴

24. R. Ahuja, *Sociology of Youth Sub Culture*, p. 6.

Society's perception of 'drug abuse' keeps changing. At any given time, there are conflicting definitions of what is 'legitimate drug use' and what is 'deviant drug-taking'. Drug taking is condemned as well as defended. This is true in the case of opium and opium derivatives like morphine, codeine etc. Narcotics like bhang, ganja, charas and marijuana have been viewed as curses of mind and as the best hope of solvation. Depressants like barbiturates and tranquillisers have their proponents and detractors. There is thus conflict about the functional and dysfunctional aspects of drugs at present.²⁵

DRUG MISUSE

'Misuse' of mind altering drugs refers to any non-specific or non-medical use of such drugs including alcohol and nicotine. The main groups of drugs which are misused by people are (1) the opiates, (2) cannabis, (3) tranquillisers, (4) barbiturates, (5) amphetamines and (6) hallucinogens.

DRUG DEPENDENCE

The term 'drug dependence' is classically defined as a 'state of periodic or chronic intoxication, detriment to the individual and society, produced by repeated consumption of a drug.' (WHO) Drug dependents are identified on the

subjectively experienced and expressed compulsion to use the drug. They indicate their inability to stay without using one or more substances of a specific category of drug and express a craving for it.

The above definition of the concept of 'drug dependence' was accepted in the multi-disciplinary national empirical survey of drug abuse among university students.²⁶

Erich Goode, however, disputes the utility of the new terminology of 'drug dependence' and the accompanying elimination of the term 'addiction', because it confuses more than it clarifies.²⁷ According to him there are drugs, both 'addicting and non-addicting' and it is not necessary that an addicting drug must cause 'psychic' or 'psychological' dependence. If one takes or is administered a truly addicting drug such as heroin, morphine, or any of the barbiturates in sufficient doses over a long period of time he/she will become addicted - that is one's cells will crave the drug, and if the drug is discontinued, he/she will undergo withdrawal sickness. It is physical dependence which is a necessary prerequisite of addiction. In contrast if one takes or is administered a non-addicting drug such as

26. Mohan etc. **Current Research in Drug Abuse in India**, p. 3.

27. Erich Goode, **Drugs in American Society**, p. 23.

marijuana over a period of time, nothing essentially will happen to him/her when he/she is 'withdrawn' from the drug. Continued administration of a non-addicting drug cannot be equated with dependence, physical or psychic.

It should be clear, then, that there are two quite separable components in the addiction - dependence equation. One is the direct physical action of the drug ; the other is how people respond, behaviourly to the physical action ; one component does not translate automatically into the other.²⁸

DRUG ADDICTION

Ken Liska says that the words 'drug addict' and 'drug addiction' have been in use most often to describe a person who has become deeply involved with one of the narcotic analgesics such as morphine or heroin.²⁹ From a medico-legal point of view addiction was considered 'a drug induced change in the physical state of an individual, such that he/she required the continued presence of the drug to function normally. Upon abrupt termination of the drug, the addict would suffer through a physical crisis, of varying degree, known as a 'withdrawal syndrome' (also termed

28. Erich Goode, *Drugs in American Society*, p.25

29. Ken Liska, *Drugs and the Human Body*, Macmillan Publishing Company, New York, 1988, p. 7

abstinence syndrome). The withdrawal crisis could be ended at any time by readministering the drug."³⁰

According to this definition, then, an addict's body somehow changes physiologically so that it requires the drug for normal existence. Further, he/she develops a tolerance to the drug, so that ever-increasing doses of it have to be taken to get the desired effect. Tolerance refers to the fact that more and more drug is needed in order to produce the same effect.³¹ It has also been defined as "as decreasing effect upon repetition of the same dose of a drug."³² This definition of addiction is still widely, applied and is useful in describing addicts of narcotics, barbiturates and alcohol, all of whom develop a physical reliance on a particular drug, develop tolerance to it, and suffer withdrawal symptoms when it is abruptly removed.

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30. Withdrawal syndrome is defined as a crisis, with varying degrees of physical and emotional severity that can accompany the abrupt removal of a drug on which a person has become dependent. Withdrawal symptoms include restlessness, irritability, stomach cramps, nausea, vomiting, diarrhea, headache etc. (Ken Liska, **Drug and the Human body**, p. 411.
31. Leach and Jordon, quoted by Nahas & Frickled), **Drug Abuse in the Modern World**, Pengaman Press, New York, 1981.
32. Isbell, H. and White, "W. Clinical Characteristics of Addicts", **American Journal of Medicine**, No. 5, 1953, p. 558.

Modern therapists claim that not all addiction results in physical reliance on a drug, and that therefore, there is not always a physical withdrawal syndrome (e.g. cocaine and nicotine addiction). Instead such drugs produce a psychic craving for the drug. Thus the term 'drug dependence' was introduced to apply to all situations in which drug users developed reliance - either physical or psychological (psychic). Tolerance is not a necessary corollary in the concept of drug dependence, which is broad and is applicable to hallucinogens and minor tranquillisers as well as hard narcotics.³³

Yet another approach, based on behaviour, has been taken to describe heavy drug involvement. Jaffe defines addiction as "a behavioural pattern of compulsive drug use, characterised by an overwhelming involvement with the use of a drug, the securing of its supply, and a high tendency to replace after withdrawal."³⁴

Addiction is viewed here as an extreme on a continuum of involvement with drug abuse. It can occur without the person becoming physically dependent or developing tolerance. Thus, habituation to a drug and pre-occupation

33. Ken Liska, **Drugs and the Human Body**, p. 8

34. Ibid. p. 8

with it are but steps on the road to overwhelming involvement. The word 'habituation' is sometimes used to refer to psychic or psychological dependence.

However, Joseph Julian maintains that some scholars prefer not to make distinctions between physical or psychological and social dependence, since there are often interrelated.³⁵ Also words like 'addiction' have come to be defined in the public mind as something evil. These scholars prefer to characterise the compulsion to use a drug simply as drug 'dependence' without attempting to define its physical or psychological components.

TRADITIONALIST VERSUS POSITIVIST APPROACH

The traditionalist approach to 'drug dependence' views it as a psychic or somatic or psychosomatic illness which manifests itself as a disorder of behaviour and is characterised by the repeated and regular use of drugs. The positivist approach refers to social functioning of the user and the need and implication of social policy. From its viewpoint, "drug dependence" is defined as habituation with a drug/or drugs that interferes frequently or continuously with the users 'social and/or economic functioning and then health. Further, it adversely affects any of their life's

35. Joseph Julian, **Social Problems**, p. 99.

important adjustment and interpersonal relationships seriously enough to cause society's conscious reaction by evolving treatment programmes. The domain of positivist definition of drug dependence is wider than traditionalist definition in the sense that it encompasses the concepts of 'social injury' (injury to society besides individual's own injury) and 'social sanctions' (including legal sanctions)³⁶.

HABITUAL DRUG USERS AND DRUG ADDICTS

The term 'habituation' is used in the mental sense that one can make a habit of doing or using anything. Once the habit of using or taking some substance (including drug) is acquired one comes to think, that it is harder to quit. However, when failing to get it, he does not feel restless, uneasy or agitated as he feels in addiction. Habituation implies psychological dependence on a particular thing or substance. In psychological dependence on a drug the abuser likes the feeling of getting satisfaction from the use of drug and wants to reexperience it. He feels a definite need for the expected drug effects, a need which may be mild or intense. The drug enables him to escape from reality from his problems, anxieties and frustrations though psychological factor underlies habituation, habit is not impulsive as addiction is.

36. R. Ahuja, *op. cit.*, p. 8.

Addiction has been succinctly dealt with in the foregoing passages. The characteristics of drug addiction are : (i) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means, (ii) a tendency to increase the dose (or frequency), (iii) a psychological and generally a physical dependence on the effects of the drugs, and (iv) an effect detrimental to the individual and on the society.³⁷ Habituation may lead to addiction if drug is used repeatedly and chronically. The qualitative difference between 'habituation' and 'addiction' can be explained in terms of the detrimental effects and the consequences of the two. Both individual and society suffer from detrimental effects of addiction whereas in the case of habituation primarily the individual suffers from them. Consequences of 'drug habituation' depend on the personality of the user, while the consequences of 'drug addiction' depend upon the properties of the drug itself and also on factors like the setting in which the drugs are taken, reliability of supply, vagaries of personal background, drug users' physical and psychic condition, the amount and frequency of drug used.³⁸

37. A WHO technical report (No. 116, 1957) reprinted in Sehur, Edwin, **Police Crimes without Policy**, Prentice-Hall, Englewood Cliffs, New Jersey, 1955, p. 122. Also referred to in R. Ahuja, op. cit., p. 9.

38. R. Ahuja, op. cit., p. 10.

8. CLASSIFICATION OF ABUSABLE DRUGS

There is no fixed and well-determined classification of drugs. Many possible classifications on the basis of characteristics and pharmacological use of drugs have been attempted. One such classification, more commonly used, is narcotics, generalised depressants, mood modifiers, hallucinogens and stimulants.³⁹ For our analysis, we may classify abusive drugs in five main groups on the basis of their effects on human body and mind. The main types are : depressants, stimulants, narcotics, hallucinogens and nicotine. Examples of some drugs with their characteristics in each⁴⁰ are presented in Table I.1

These drugs can also be classified as psychotropic, narcotics and recreational. The first group includes anti-depressants, tranquillisers, stimulants (amphetamines) and sedatives (barbiturates) and have legitimate application in medicine. The second group includes opiates, cannabis (cannabinoids), cocaine etc. The third group includes alcohol and nicotine and aims at pleasurable and harmless fun.

39. Richard C. Stephens, **Mind-Altering Drugs**, SAGE Publications Inc., California, 1987.

40. Ronald Akers, **Deviant Behaviour**, Wadsworth Publishing Co., California, 1973, p. 68

TABLE 1

CLASSIFICATION OF DRUGS WITH EXAMPLES IN EACH CLASS

S.No.	Class	Examples	Characteristics
1.	Depressants or Sedatives	Alcohol, Barbituates Tranquilizers, Pain-killers, Anti-anxiety drugs	1. Relax central nervous system (CNS) 2. provide a calming, soothing affect 3. Induce sleep
2.	Stimulants	Ambitamines	1. Relieve tensions and emotional distress 2. Stimulate CNS 3. Counteract fatigue or drowsness 4. Reduce aggressive inhibitions 5. Induce insomnia
3.	<u>Narcotics</u>		
a)	Opites	a) Opium, Codeine morphine, pathidine heroin	1. Produces depressing affect on CNS 2. Create feelings of pleasure, strength and superivity 3. Increase suggestibility
	Cannabinals	b) hashish, Charas Ganja, Bhang	
4.	Hallucinogens	L.S.D.	1. Produce distortions of perception dream images, hallucinations
5.	Nicotine	Tobacco, Cigarettes Cigar, Bid'i, Snuff	1. Stimulate CNS 2. Lead to relaxation 3. Remove boredom and increase wakefulness

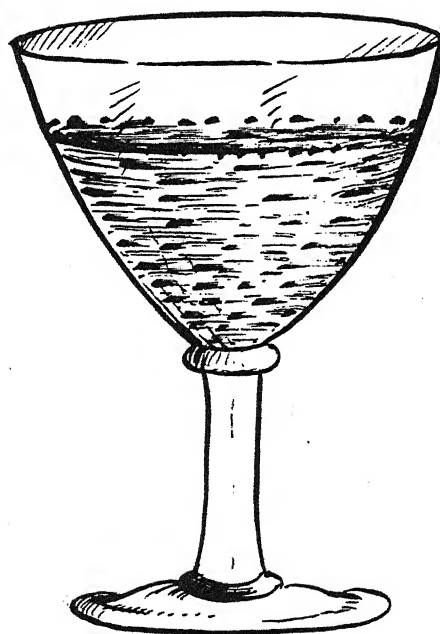
9. DEPRESSANTS OR SEDATIVES

Stimulants and depressants cover a wide range or heavily consumed substances. Some are available to any one over a certain age, others are available by prescription - to say, very easily available. Theoretically at least, stimulants and depressants have opposite effects, but under certain circumstances, stimulants have a sedative effects, and other circumstances depressants are excitative in impact. The depressants include alcohol, barbiturates and tranquillizers, as well as narcotics under separate type because they have important effects in addition to depression.

Sedatives relax the central nervous system, induce sleep and provide a calming effect.

ALCOHOL

The substance commonly referred to as 'alcohol' is actually one of many different kinds of alcohols. It is known to scientists as ethyl alcohol or ethanol. Alcohol has a depressant action on the central nervous system, as do the barbiturates and the narcotics. It is also an anaesthetic - it deadens pain in the body. The effects of liquor are highly dependent on dose. Highly concentrated drinks like vodka, gin and whisky have much more of an impact than drinks of lower alcohol concentration such as beer or wine.



DRUG IS INJURIOUS TO HEALTH

Alcohol in contrast to other drugs, is integrated into cultural mores and is believed to facilitate interpersonal relations. For some, the use of alcohol is a normal, pleasant, sociable activity ; for others it is a spur to enable them to work, or a sedative to calm down, or a kind of anaesthetic to dull the pain of living.

By almost any criterion, alcohol is probably the most serious drug problem in India today, with tobacco consumption running a strong second. Other problems related to alcohol abuse are staggering, for example, mental and physical illness, disorderly behaviour, traffic accidents, crimes especially violent crimes including sex crimes etc.

It is unfair to compare the medical and social pathologies associated with alcohol with those of other drugs, for the simple reason that alcohol is used to a far greater extent. There are not only more pathologies, but more neutral and beneficial experiences with the drug (alcohol). Most people who drink alcohol moderately or occasionally find their experiences with the drug positive and rewarding ; they suffer no pathology, whatsoever, medical or otherwise.⁴¹ The drug is typically a mild and pleasant accompaniment to meals, recreational events, social

41. Erich Goode, *Drugs in American Society*, p. 144.

intercourse, celebrations and even religious occasions. In small quantities it may enhance sexual pleasure, facilitate business deals, ease social awkwardness, ally tension and anxiety, increase confidence, and make otherwise drab activities pleasurable. But heavy and/or continuous doses of alcohol lessen sexual and aggressive inhibitions, cause distorted visual and sensory perceptions. It impairs judgement and creates confusion. Alcoholism is certainly a serious social problem.

Many studies have revealed the increasing alcohol abuse among young people to the extent that there are three or four times as many drinkers as other drug users.

BARBITURATES AND TRANQUILLIZERS

Barbiturates and tranquillizers, like alcohol and heroin, are general depressants of a wide range of bodily functions. Barbiturates are usually taken orally as a tablet or capsule although they can be taken intravenously too. Medically they are used in high blood pressure, insomnia, epilepsy and to relax patients before and during surgery. As depressants they depress nervous and muscular activity. They lower blood pressure and slow down breathing and heart rate. When used in small quantities, they induce relaxation, good

humouredness, and sociableness but in higher doses they make the user sluggish, gloomy and sometimes irritable and quarrelsome. Also his ability to think, concentrate and work is impaired and his emotional control is weakened. These effects resemble alcohol intoxication. Barbiturates thus become extremely dangerous when taken without medical advice. They are found to be high on the list of suicidal poisons.

Different types of persons abuse barbiturates for different reasons i.e. (1) for relieving emotional distress ; (2) for supposedly increasing efficiency, through self exhillaration and animation ; (3) for counteracting abuse of various stimulant drugs such as amphetomines, for example, individuals taking pep-pills (stimulants) to function in day time and then taking a sedative to sleep at night ; and (4) for obtaining hightened effects from barbiturates in combination with alcohol and/or opiates to surpass the effects of either (i.e. alcohol or opiate).⁴²

Barbiturates are physically addicting sometimes the physical dependence is more dangerous than dependence on narcotics like opium, morphine and heroin. Many experts consider barbiturate addiction more difficult to cure than

42. See Harold D. Love, *Youth and the Drug Problem*, p. 10.

narcotic dependence. When barbiturates are withdrawn abruptly, the abuse suffers from cramps, nausea, delirium, convulsions and coma. Barbiturate withdrawal is even more severe and life threatening than withdrawal from heroin. It is much more likely to result in death. It, therefore, should take place over a period of several weeks and on gradual reduced dosages.⁴³

Tranquillisers are divided into 'major' and 'minor'. The major tranquillisers like Thorazine (chlorpromazine) are useful in suppressing some symptoms of mental illness and are not used, either legally or illegally, outside the context of anti-psychotic therapeutics. The 'minor' tranquillisers include a chemically miscellaneous group of sedatives, most well known of which are librium (chlorodiazepoxide), Valium (diazepam), Equanil, Methaqualone and Placidyl. They are used to counteract tension without impairing mental and physical function. Chronic use of these drugs results in physical and/or psychological dependence. The symptoms of abrupt withdrawal resemble that of barbitrates.

43. R. Ahuja, **Sociology of Youth Subculture**, pp. 11-12, and Erich Goode, **Drugs in American Society**, p. 153.

10. STIMULANTS

The stimulants include amphetamines, methedrine, cocaine, caffeine and nicotine. The most widely known stimulants are amphetamines, popularly called 'pep pills', alcohol and cigarettes/bidis/eatable tobacco preparations. The effect of stimulants on central nervous system is stimulating. The stimulants also relieve tensions, treat mild depression, induce insomnia (keep a person awake), counteract fatigue and excessive drowsiness, and lessen aggressive inhibitions.

Moderate doses of amphetamine as per medical advice can check fatigue and provide feelings of alertness, self-confidence and well being. Heavier doses cause extreme nervousness, headache, sweating and diarrhea.

Stimulants are popular among all sections of society, housewives, businessmen, students, athletes, truck drivers and others. They are usually taken orally, some (like Methedrine) are taken by intravenous injection.

Even the continued use of stimulant drugs does not produce physical dependence, though the user's body develops tolerance to these drugs. However, psychologically addicting characteristics of these drugs are evident in habituation to them for mental or emotional reasons. Long term heavy users of amphetamines are usually irritable and unstable. they

also show varying degrees of intellectual, emotional, social and economic deterioration. Abrupt withdrawal of the drug results in mental illness and a deep suicidal depression. Use of amphetamines, particularly methedrine, in successively increasing huge doses, has deep impact on the lives of users, not qualitatively different from that of heroin addiction, in fact in many ways, it is greater. They become 'speed' freaks.⁴⁴

11. NARCOTICS

Narcotics include (a) opiates : opium, codeine, morphine, pethidine, heroin, cocaine and (b) cannabinols : marijuana, hashish, charas, ganja and bhang.

Heroin is a white powder derived chemically from morphine, which in turn is derived from opium. Opium is dried juice of poppy plant grown principally in South East Asia, Middle East (Turkey) and Mexico. All the various alkaloid products are called 'Opiates' and they include opium, morphine, heroin, codeine and cocaine. There are also a number of synthetic narcotics of which methadone and meperidine under different brand names are very popular. Cocaine is made from the leaves of coca bush and is

44. Erich Goode, **Drugs in American Society**, p. 134.

odourless, white crystalline powder with a bitter taste. Cannabis is obtained from the hemp plant ; and marijuana is a particular form of cannabis.

Narcotics are pain-killers or analgesics. They tend to reduce sensory sensitivity - to pleasure as well as pain. They also tend to inspire drowsiness and sleep. Like sedatives they produce depressant effect on the central nervous system. They produce feelings of pleasure strength and superiority, reduce hunger, thirst and sex drive, lessen inhibitions and increase suggestibility.

Moderate doses of opiates are medically used as painkillers. These drugs reduce short term acute pain resulting from surgery, fractures and burns etc. Larger doses depress the brain and produce sensations which may be brief or high lasting several hours.

Heroin, morphine, pethidine and cocaine are used either by inhaling (the powder) or injecting the liquified form. Opium and marijuana may be smoked, sniffed or ingested. Charas, Ganja and hashish are also smoked. Bhang ground with spices etc. is used in liquid, goli or paste form, usually with 'sharbat'.

As analgesics, narcotics are of immense therapeutic value. But they are also, without exception, physically addicting. Besides building tolerance, they cause addiction much more quickly than barbiturates and alcohol etc. It is possible to be heroin addict within a matter of weeks. As with the other depressants, heroin has a very narrow range between, effective dose and lethal dose.⁴⁵

The withdrawal symptoms vary with the degree of physical dependence. After eight to twelve hours after last dose the user shows symptoms like shaking, sweating, chills, diarrhea, nausea, mental anguish, abdominal and leg cramps. Thereafter symptoms increase in intensity, climaxing between 36 to 72 hours and then gradually diminish over the next 5 to 10 days. However, weakness, insomnia, nervousness and muscle pains may persist for several weeks.

One of the more interesting medical facts about heroin and other narcotics is that aside from the danger of overdosing, they are relatively non-toxic drugs. Unlike alcohol, the amphetamines, and the barbitrates, which are toxic to the body over the long run with relatively heavy use, the narcotics are relatively safe. The organs are not damaged, destroyed or threatened by even a lifetime of narcotic addiction.⁴⁶

45. Erich Goode, **Drugs in American Society**, p. 161.

Withdrawal from narcotics also appears to be relatively non-life threatening in contrast with barbiturate withdrawal.⁴⁷

12. HALLUCINOGENS OR PSYCHEDELICS

Hallucinogens, a group of drugs, not accepted for use in medical practice are called mind-altering drugs. The well known drug in this group is L.S.D. which is a man-made chemical. It is so powerful that one ounce produces three lakh human doses. An amount literally smaller than a grain of salt can produce gross psychotic reactions in human beings. LSD may be obtained as a small white pill, as a crystalline powder in capsules or in liquid in ampoules. Usually LSD is taken orally but it may also be injected. The effect of an average dose of LSD usually lasts from 8 to 10 hours.

Hallucinogens produce distortions of perception (seeing or hearing things in a different way than they actually are), dream images and hallucinations.

There are naturally occurring psychedelic drugs as well as synthetic hallucinogens. Psychedelic experiences have been called wiered and bizarre perceptions beyond

47. Erich Goode, **Drugs in American Society**, p. 165.

'normal' reality, exclusively subjective to the users.⁴⁸ Some psychotic episodes have also been reported. They are extreme emotional disturbances produced by hallucinogenic drugs.

Panic reactions, depressive reactions and permanent mental derrangement can result from an attempt to withdraw from the use of L.S.D.

13. NICOTINE

Legally incotine is not a classified drug. It has no medical use. This includes cigarettes, cigars, bidis, snuffs and tobacco, smoked or chewed as eatable along with other substances, which form ingredients of 'pans' and 'pan-masalas' or 'khaini' (surti). The risk of physical dependence on nicotine, however, may be there.

Frequent or heavy use of nicotine may cause heart attack, lung cancer, bronchitis etc. Nicotine is a psychoactive drug, but its use is associated with socially and culturally established habits'. Excessive nicotine use in any form causes many serious diseases, which are transmitted genetically with ever-increasing health hazards for younger generations.

48. Erich Goode, **Drugs in American Society**, p. 112-115.

CHAPTER - II

APPROACHING THE PROBLEM

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1. PSYCHO-SOCIAL ASPECT OF DRUG ABUSE

Drug use is not only a physiological and medical problem, it also has some very far-reaching psychological and social implications. In the countries where drug abuse has become very pervasive and dreadful, it has assumed the form of a social problem. As a social problem, it is not only a matter for criminal prosecution but a matter for understanding as to what type of social and cultural forces generate tendencies towards drug abuse. The analysis of drug abuse problem in this study is primarily the analysis of social, psychological and psychiatric aspects of the problem. We have refrained from treating it precisely as a social problem.

Drug abuse is the product of an extraordinary complex interaction between man and his community (or environment). Because of the social impact of drug taking behaviour and the fear and misunderstanding drug abuse engenders in public objective analysis of this problem has been hampered by man's preconceived notions. Carefully designed epidemiologic studies and proper analysis and

interpretation of collected data can help us to separate facts from fancy in this highly emotional and debated topic. Moreover the results of such research studies can have a significant bearing on the development of drug abuse control policy.¹

Epidemiology of drug abuse may be defined as the study of distribution of drug abuse in human population and its causative factors. The main purposes of an epidemiologic study of this problem are : (a) to provide necessary data in understanding the magnitude and spread of the problem ; (b) to study its causative factors ; and (c) to devise curative and preventive measures, based on these two types of information. In descriptive type of such study distribution of persons abusing various kinds of drugs according to various facts such as sex, age, residence, religion, socio-economic status, educational level etc. and the progression of this problem over a time period are studied. In analytical type of different hypotheses about the causative factors in the development of drug abuse are studied and tested for their statistical significance. The present study is analytical type of epidemiological research.

1. D. Mohan etc., **Current Research in Drug Abuse in India**, p. 9.

2. ANALYTICAL STUDIES

There are two basic approaches in investigating the relationship between variables. Analytical studies are called observational studies where nature is allowed to take its own course (or phenomenon) and changes in one characteristic are related to change in the other, if any. In the experimental approach, the investigator actually intervenes and makes one variable change and then sees what happens to the other.

The analytic epidemiological study can be of two types : (1) Comparison of people abusing drugs and normal people showing that the determinant occurs more frequently among those with drug abuse than those without and (2) Comparison of people exposed to the determinant and those not exposed showing that a greater proportion of people develop drug abuse among the exposed population than among the non-exposed. Constructing a control group comprising of normals/non-exposed and making comparison of the observations, with the affected exposed is the crux of the analytical epidemiological investigation to find out possible significant association of a causative factor in determining the effect. A case control study which is conducted retrospectively is designed to conduct the first

type of study. A group of people affected with disease (drug abuse) is identified and concurrent control groups of normals is constructed and the observations are compared statistically to find out the significant causative factors in determining the disease (effect).²

3. QUESTIONS TO ANSWER

It should be made clear, at the outset, that our study is concerned with drug abuse and not with drug addiction or drug dependency. In this micro-level survey of drug abuse among college/university students residing in hostels in Jaipur city, we have attempted to answer a number of relevant questions pertaining to drug abuse problem. How has the problem of drug use among this section of population become so many faceted in our society ? What is the frequency of use of different drugs ? What is the nature and extent of drugs abused by these students ? What kind of students use drugs ? Why do they take drugs ? What are their sources of getting drugs ? What is the process of their initiation and induction of drugs ? What are the conditioning factors that promote drug use ? What are the

2. Ibid. p. 11

consequences of using drugs ? Are the users aware of these consequences ? How awareness affects their drug using behaviour ? What efforts do they make to withdraw from drugs ? What type of success, if any, is achieved by them ? How can we control or prevent drug use among students ? What alternative approaches to explain students drug behaviour exist ? It is possible to evolve a useful sociological theory to explain such behaviour ?

4. THEMATIC DIMENSIONS OF THE STUDY

Broadly speaking, the thematic structure of this epidemiological research consists of following major dimensions :

- (1) to determine the nature, magnitude and pattern to prevalence of drug use among college/university students residing in hostels.
- (2) to study the demographic and socio-cultural background of drug users.
- (3) To examine the motivational and conditioning factors in drug use.

- (4) to find out in-depth correlations of family and peer interactions facilitating or inhibiting drug consumption or to identify structural and cultural conditions that generate tendencies toward drug consumption.
- (5) to analyse the process of initiation and induction in drug use.
- (6) to locate the sources of getting drugs.
- (7) to analyse the effects of drug use.
- (8) to identify potential students who may take to drugs.
- (9) to study the attempts to withdraw or abstain from drugs ?
- (10) to point out the concern and effort of the society for development of preventive and control measures to check drug abuse.

REASONS FOR CHOICE OF THIS PROBLEM

A brief personal note on the reasons for choice of this problem for research. What impelled this investigator to undertake it ? The investigator himself was

a hosteler in his college days. Then as a college lecturer he has had the opportunity to work as a hostel warden for a few years. These situations furnished him with numerous occasions to acquire intimate and diverse acquaintance with life in hostels manifested through hopes and aspirations as well as anxieties and frustrations of the inmates. The inmates develop a particular type of psycho-social set-up and action pattern to cope efficiently with the congenial and not so congenial aspects of hostel life. It evolves in involuntary isolation from the family, kinsmen and friends, neighbourhood and community which together served as pre-college days' social environs of the inmates. The previous heterogenous groups of students gradually fuse into a sort of homogeneous community with its peer groups and associational constituents. The typical socio-cultural milieu shapes into a vibrant and vigouroves youth sub-culture.

The Wardens, prefects and senior inmates of the hostels serve largely as friends, guides and philosophers of the inmates. The hostelers experience typical needs and problems and develop their unique forms of understanding and solving them. The hostels serve as fertile soil for growth of ' non-conventional and seemingly 'revolutionary' or

anti-traditional social behaviour. In fact, such a behaviour with deviant behaviour as one of its variants is the natural outcome of the overflowing youthful energy and urge for self-identity and experimentation. Formation of peer groups occasionally indulging in novel exhilarating and exciting activities is a common phenomenon. Individual or group rivalries sometimes erupting into ugly scenes and brawls on petty issues, false notions of prestige or misunderstandings are also not very uncommon occurrences. Also some socially and culturally outrageous activities, grossly vulgar and atrocious inhuman acts and seandalous criminal incidents punetuate the generally placid and peaceful life of hostels.

This disparaging aspect of hostel life has been noticed directly or indirectly associated with abuse of drugs like heroin, hashish, alcohol or smack etc. Abuse of drugs impairs user's discreation and benumbs his finer social and moral sensibilities. It causes morbidity in users and incites them to behave abnormally detrimental to individual and social interest.

This investigator observed on some occasions the deleterious effects of drug abuse among hostel inmates. Many of them allegedly involved in despicable behaviour like the aforementioned confessed having done so under the influence

of drug. On becoming normal they felt invariably ashamed of their misconduct and apologised sincerely for their indiscrete acts. They were full of genuine remorse and appeared deeply apprehensive of discontinuation of their studies if their misconduct was reported to their guardians/hostel authorities.

During his wardenship, some stray cases of unexpectedly erratic and violent behaviour of drug users also came to notice. A certain youngman, infalmmmed at a mere joke, attacked his room mate with a razor and injured him grievously. Another youth-created utter nuisance in the common room and smashed furniture and windowpanes. A third drug user in the first flush of intoxication, jumped in to the swimming pool unmindful of the risk involved. Yet another drug addict frustrated by failure in examination attempted suicide by hanging from the ceiling fan. Some drug addicts were also alleged to be involved in selling goods stolen from inside the hostels or from other places just to pay for drugs. Thus such incidents, though quite rare and sporadic, are indicative of the potential dangers of drug abuse among the youth. This realisation further propolled this researcher's choice of the present theme.

The hostels in Jaipur city offer rich field for study of drug use among students. Their inmates hail from different parts of Rajasthan State, and India and also from abroad. The pink city of Jaipur offers excellent opportunities for higher education in moder disciplines including medicine, engineering and technology. A variety of hostels, lodges and boarding houses provide loding and boarding facilities to more than five thousand students. Jaipur is a major tourist attraction. It abounds in tourist and luxuarious hostels, magnificent archeological and historical monuments, buildings of architectural splendour and places full of natural scenic beauty.

It is also famous for its resplendent culture, religious shrines, colourful costumes and traditional gaiety and enthusiasm of fairs and festivals. As the hub of political activity, the centre of administration and modern trade and industry, city is replete with a variety of amusement and recreational centres. All of these have their immense fascination for the youth. They are often induced to some form of drug consumption for it has acquired some respectability in a modern urbanized society through still retaining its vital cultural moorings.

6. DESIGN OF RESEARCH

Before we decided about one particular design several alternative designs were considered for conducting the survey. One was a longitudinal design, i.e., to interview students some days after they started living in hostels and follow up the drug users from them after three or four months. The advantage of this design would have been that it would have enabled us to be sure of the casual factors of drug-taking. The assumption was that a small sample of actual drug users would give more detailed data and it would be possible to compare these subjects on a number of variables with those who had not tried drugs. If any difference had then been found, dependent on the extent to which it was possible to control other factors, it would have been viable to say that these differences were probably contributing factors as to why some subjects took drugs and others did not. However, after consideration it was practically found impossible. The hostels started functioning only in the month of September instead of July - August of 1989. The first stage interviews could have been started only by the end of September which continued upto February, 1990. As such selecting actual drug users from this sample and reinterviewing them after two-three months' interval was impossible. With the close of teaching in

colleges and university in the second week of March the hostelers engaged themselves seriously in studies to prepare for annual examinations in April-May. It became extremely difficult to establish contact with them and snatch even a little time from their busy schedule. It was, therefore, for lack of time and facilities that idea of employing a longitudinal design was abandoned.

The second alternative considered was to interview each selected respondent personally. But this idea had also to be rejected for reasons of confidentiality. Drug taking is an illegal activity and it was felt that if the respondents knew that they could be identified they would be less likely to tell the truth.

Another approach was to select the respondents from three boys' University hostels, three girls' University hostels, two private girls' college hostels and two Engineering and Medical Colleges hostels out of a large number of the college/University hostels in each of three categories of hostels in the city. But it was thought that this approach might prevent a cross-sectional analysis.

The design of study finally chosen was to rely on stratified random sampling of respondents from all the

college/university hostels after first placing them under two broad categories - professional and non-professional and then further sub-dividing them on the basis of under-graduate and post-graduate standard/class. The undergraduate and post-graduate (including those pursuing courses of higher studies such as LL.M., M.Phil., Ph.D., Research Fellows, M.S., M.D., M.Engg., M.Tech. etc.) respondents were categorised classwise. Thus the sample chosen comprised units from all the three strata of the universe on proportional basis to make it fairly representative of the universe and adequately suitable for a cross-sectional analysis. This approach had its added advantage in that, it enabled us to examine differences not only between drug users and non-drug users but also, to explore relationships between particular variables.

In every research design the researcher's main concentration should be on different types of variables acting and reacting with the problem under study - both dependent as well as independent, controlled and uncontrolled. In our study the dependent variable was whether the student took drug or not (drug user, non-user), the independent variable was any factor that affected the use or non-use of drugs (dependent variable) such as, family, peer group,

community environment in a wider sense etc. The controlled variable prevents the factors other than the independent ones from affecting the dependent variable. We controlled these factors by surveying all the units of the sample at one time, that is, by completing the entire survey within a limited period of five months, and by matching each drug user with a control group on the factors of sex, faculty, professional or non-professional course of study and class. Thus a cross-sectioned design was chosen within which a basic measure of control was obtained by matching the drug users with non-users on a number of variables.

7. THE UNIVERSE AND THE SAMPLE

The universe of this study were all the hostel residing under-graduate and post-graduate students studying in various colleges and Campus Departments of the University of Rajasthan at Jaipur, the capital of Rajasthan. For the students belonging to post-graduate departments of the Faculties of Social Sciences, Natural Sciences, Humanities, Commerce and Law the hostels assigned are located inside or near the Main University Campus. The two multifaculty under-graduate constituent colleges of the University viz. the Maharani's College and the Maharaja's College, located about $1\frac{1}{2}$ Kilometer north of University Campus have their

separate attached hostels, Annie Besant Hostel and Gokhale Hostel respectively. The two privately managed girls Colleges, Kanoria College and Sat Sai College, both multifaculty and under-graduate, also have their own separate hostels. The colleges/institutes belonging to the Faculty of Medicine and Pharmacology, namely S.N. Medical College, National Institute of Ayurveda and Homoeopathic College, have their own hostels for under-graduate and post-graduate students. So is the case with the Engineering and Technology College. All the hostels of two privately managed girls colleges, Ayurvedia Institute, Medical College, Homoeopathic Colleg and Engineering College are located inside the city of Jaipur separated by short and long distances from the main University Campus or nearby hostels.

The total number of the hostels run by the University, private girls colleges, Medical College, Homoeopathic College, National Institute of Ayurved and Engineering College is 19 and the total number of student residents in them at the time of survey (September, 1989 to February, 1990) was 3000. Of them 2406 were males and 594 females, making female - male ratio roughly 1:4.

For purposes of our study, we divided all the resident students into two broad categories : (i) professional and (ii) non-professional. Those pursuing

courses of study under the faculties of Social Sciences Humanities (Arts, Fine Arts and Dramatics), Natural Sciences, Law and Commerce were placed under the category of non-professional and those studying medicine, including Ayurveda and Homoeopathy and Pharmacology and Engineering and Technology were categorised as professional. Students pursuing management studies in the R.A. Poddar Institute of Management were also included in the professional category. However, in the case of Law students, we did not find it advisable to include them in the professional category for only a small number of them opt for legal or judicial career after completion of their studies.

The two categories of professional and non-professional students were further sub-divided into undergraduate and post-graduate students and then according to classwise. However, the whole class was taken as a unit of study.

The details of professional students residing in hostels of various colleges are as follows :

1. Medical College

Undergraduate males	:	80
Undergraduate females	:	60
Post-graduates males	:	40
TOTAL	:	180

2. National Institute of Ayurveda

Under-graduate males	:	90
Post-graduate males	:	10
TOTAL	:	100

3. Homoeopathic College

Under-graduate males	:	70
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4. Engineering College

Under-graduate males	:	900
Post-graduate males	:	6000
TOTAL	:	1500

University run Men's Hostels are occupied by non-professional students :

5. a) Ambedkar Hostel

Post-graduate	:	60
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6. b) H.J. Bhabha Hostel

Postgraduate	:	96
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7. c) D.B.N. Hostel

Post-graduate	:	61
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8. W.U.S. Hostel

Post-graduate	:	23
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9. e) J.C. Bose Hostel
Post-graduate : 61
10. f) Gokhale Hostel
Under-graduate : 150
11. g) Vivekanand Hostel
Under-graduate : 66
12. h) Maharana Pratap Hostel
Under-graduate : 65
13. i) Raman Hostel
Post-graduate : 34

University run Women's Hostels as well as private-colleges run hostels are also occupied by non-professional students :

14. Annie Besant Hostel
Under-graduate : 125
15. Kasturba Hostel
Post-graduate : 67
16. Malviya Hostel
Post-graduate : 96
17. Laxmibai Hostel
Post-graduate : 66

18. Kanoria College

Under-graduate : 45

19. Sat Sai College

Under-graduate : 135

Thus our universe comprised 1850 professional students (1120 under-graduate males, 60 females and 670 post-graduate males). The non-professional hostellers component of the universe was 1156 (305 under-graduate, and 235 post-graduate females, 342 under-graduate and 274 post-graduate males).

Table 2.1

Coursewise, Facultywise and Sexwise
composition of the Universe

S.NO.	COURSE OF STUDY FACULTY	UNDER-GRADUATE		POST-GRADUATE		RESEARCH		TOTAL		
		M	F	M	F	M	F	M	F	T
	<u>NON-PROFESSIONAL</u>	342	305	179	169	95	66	616	540	1156
1.	SCIENCE	150	50	70	60	81	25	301	135	436
2.	SOCIAL SCIENCE	40	103	27	32	4	11	71	146	217
3.	ARTS	26	62	18	27	2	7	46	96	142
4.	COMMERCE	65	90	64	50	8	23	137	163	300
5.	LAW	61	-	-	-	-	-	61	-	61
	<u>PROFESSIONAL</u>	1120	60	670	-	-	-	1790	60	1850
6.	MEDICINE	220	60	70	-	-	-	290	60	350
7.	ENGINEERING	900	-	600	-	-	-	1500	-	1500
	TOTAL	1462	365	849	169	95	66	2406	600	3006

We decided to select a 10 per cent sample of the universe through stratified random sampling with a view to make it fairly representative of the universe and to facilitate a cross-sectional analysis of drug abuse among hostelers.

Our sample then comprised 185 professional students - 118 under-graduate (112 males and 6 females), 67 post-graduate males ; and 115 non-professional students - undergraduate males and females being 33 and 31 and post-graduate males and females being 28 and 23 respectively.

Table 2.2

**Composition of the sample
(Coursewise, Facultywise and Sexwise)**

S.NO.	COURSE OF STUDY FACULTY	UNDER-GRADUATE		POST-GRADUATE		RESEARCH		TOTAL		
		M	F	M	F	M	F	M	F	T
	<u>NON-PROFESSIONAL</u>	33	31	18	17	10	6	61	54	115
1.	SCIENCE	15	5	7	6	8	3	30	14	44
2.	SOCIAL SCIENCE	4	10	3	3	-	1	7	14	21
3.	ARTS	3	6	2	3	1	-	6	9	15
4.	COMMERCE	6	10	6	5	1	2	13	17	30
5.	LAW	5	-	-	-	-	-	5	-	5
	<u>PROFESSIONAL</u>	117	6	67	-	-	-	179	6	185
6.	MEDICINE	22	6	7	-	-	-	29	6	35
7.	ENGINEERING	90	-	60	-	-	-	150	-	150
	TOTAL	145	37	85	17	10	6	240	60	300

The facultywise composition of the sample was Arts faculty 5.00 per cent, Social Sciences faculty 7.0 per cent, Science faculty 14.7 per cent, Commerce faculty 10.0 per cent, Law 1.7 per cent, Medical faculty 11.7 per cent and faculty of Engineering and Technology 50.00 per cent. Some foreign students from Nepal, Iraq, Iran, Kenya, Nigeria and Zambia also formed part of the sample.

8. METHODOLOGY

To conduct the research in two or more stages was not found practicable for lack of time and facilities. The investigation was spread over a period of five months. First, to assess the nature and extent of prevalence of drug abuse, a self-administered questionnaire was distributed among all the students of the sample with the assurance that the information would be kept confidential and used strictly for scientific purposes.

The questionnaire consisted of 31 questions on demographic and socio-economic aspects and 31 questions on drug use.

Detailed information pertaining to demographic and socio-economic characteristics of the respondents, awareness and knowledge of drug abused, the actual pattern of usage, drug first used, mode of taking drugs, source of obtaining

them, etc., were collected. Through the questionnaires information regarding the respondents' reason for taking or not taking drugs and attitude towards drug use was also collected. The respondents were personally approached in some cases twice or thrice, to ensure that non-response is almost eliminated and questionnaires, filled in freely and frankly, are returned to us in time.

A preliminary analysis of the data collected through questionnaires provided the base material for indepth study carried out through an interview schedule.

Here only the drug users in the sample were covered. This helped us in understanding the psychological and sociological factors motivating drug abuse, conditioning factors and respondents attitude towards the problem of drug abuse and its control. The indepth study also helped to cross-check and varify the statements of the respondents and observations about their behaviour within the peer group situations. The interview schedule used for indepth study consisted of 62 questions covering all the aspects of the problem. The data was carefully processed so as to make it useful for analysis and interpretation.

The respondents were divided into three categories on the basis of their drug taking behaviour : (i) those who had never taken drugs (non-users). These constituted the second largest group (28.7 per cent) in the sample. (ii) Those who had tried drugs earlier but discontinued them (past users). Past users are persons who used a drug at least once but were not using the same during the past 6 months. Drugs for them were only to taste or for just an experience. They constituted 13.0 per cent of the sample. (iii) Those who were using drugs at the time of study (current users). The current users, the largest group (58.3 per cent in the sample), were further sub-divided into three sub-categories (a) occasional or experimental users, (b) regular users, and (c) addicts or dependent users. Non-addict occasional or in regular users are such current users who use drugs occasionally or even in regularly and are not 'dependent' on drugs, though they plan to continue experimentation. These people have not organised their lives around drugs. Drugs for them are for 'kicks'. These students constituted a considerably larger group (70.9 per cent) in the category of current users. Here occasional or experimental users were taking drug/s about once a month or less often. These two categories of students formed 70.9 per cent and 21.7 per cent respectively of the current users.

Addict current users on 'dependents' were those users who indicated their inability to stay without drug/s and expressed a craving for it/them. These are 'hard core' users who cannot live without drugs. Drug use for them is an exclusive or dominating concern and activity. Their activities revolve almost entirely around drug experiences and securing their supplies. They constituted a smaller group (7.4 per cent) in the category of current users.

Table 2.3

**Drug-users and Non-users
in the sample**

No. of Respondents	Non- users	Past- users	Current Users (58.3% of sample)			
			Exp.	Regulars	Addict	Total
M 240	80	34	87	27	12	126
F 60	6	5	37	11	1	49
T 300	86	39	124	38	13	175
% 100.0	28.7	13.0	70.9	21.7	7.4	100.0

For the analysis of the various aspects of drug use, data obtained from both the questionnaires and the interview schedules were treated as 'one compositive' base material. At this level, the study has wider significance theoretically, as well as in regard to social policy.

9. LIMITATIONS OF THE STUDY

It would be in order to point out some limitations, though minor of the present study. First, it has a more restricted scope in the sense that only college and university students residing in formally run hostels (to the exclusion of privately run or community supported hostels and lodges) in Jaipur city formed the universe of study. The excluded category of hostels/lodges/boarding houses was having about 2000 occupants - mostly college and university students. Secondly, this study would not be comparable in terms of its findings etc. with any study which encompassed all the college and university students - both residents and non-residents - in a large cosmopolitan city like Jaipur. Thirdly, to determine the precise tendency of increase or decrease in the extent of prevalence, in nature and incidence of drug taking behaviour, a superior and more meaningful design of research would advisably be a two-stage survey covering a period of at least three years.

And lastly, perhaps a non-teacher researcher (the present researcher being a local college lecturer) would have been better suited to carry out research in such a highly emotive and socially implicative problem with moral

overtones. This, however, should not imply that present study with its design and parameters lacks authenticity or its methodology was vitiated in validity and objectivity in any form or manner.

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CHAPTER - III

NATURE AND EXTENT OF DRUG USE



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CHAPTER III

THE NATURE AND EXTENT OF DRUG USE

One of the core questions mentioned in the preceding chapter is about the extent of use of drugs - misuse of the legal drugs or the use of the illegal drugs. How widespread is the use of alcohol, tobacco, stimulants, depressants, narcotics and hallucinogens ?

But before we proceed to analyse the extent or incidence of drug use it is important to note the meaning of extent. It would not be correct to include in this definition (of extent) all those students who have at any time used the illicit or exotic drugs. The correct picture of extent could be given if we confine our analysis to 'current users'. This is the position we have adhered to here in regard to definition of 'extent'. We have mentioned separately the number of 'past users' along with the number of 'current users' to facilitate comparative analysis. But for making generalisations we have combined these two categories of current users and past users - to calculate the total percentages.

1. INCIDENCE OF DRUG USE

In a study of drug abuse among college/university students of Jaipur conducted in 1976¹ it was found that 36 per cent students (current users and past users together) had at one time or another experienced drugs (including alcohol and tobacco). Another study of the drug use among the same population in 1986 revealed that the majority of students (93.4 per cent) reported not using anything. Only a small percentage (6.00) confessed using one or more of these drugs either currently or in the past.

The findings of our study are, however, at striking variance with those of the above mentioned studies. Here an overwhelming majority (71.3% of our sample), consisting of 13.0 per cent past users and 58.3 per cent current users) confessed using one or more drugs. Those who never used any drug were found to be only 28.7 per cent of the sample. Thus the greater incidence of drug use among hostel inmates may be said due to two reasons : One, the hostel inmates are far removed from their families and so parental control exercised on them is much less as compared with that on students living in their families. Also, the hostel inmates are influenced by their peers in making experiments and

1. Ahuja, R., *Sociology of Youth Sub-Culture*, p.22

trying to behave more freely. Two, since our sample had relatively larger component of professional students (61.7 per cent), the greater incidence of drug use among sampled students is most probably due to the wider prevalence of drug use among professional inmates compared with non-professional inmates.

TABLE 3.1

TYPE AND NUMBER OF DRUGS USED BY DRUG USERS IN THE SAMPLE

S.No.	Drug usage	Males	Females	Total
1.	Non-Users	80 (33.3)	6 (10.0)	86 (28.7)
2.	Past Users (tried earlier but discontinued)	34 (14.2)	5 (8.33)	39 (13.0)
3.	<u>Current Users</u>			
(i)	Tobacco or alcohol or both	65 (27.0)	25 (41.7)	90 (30.0)
(ii)	Tobacco or alcohol or both plus drugs	44 (18.3)	20 (33.3)	64 (21.3)
(iii)	Only one drug	12 (5.0)	3 (5.0)	15 (5.0)
iv)	More than one drug	5 (2.1)	1 (1.7)	6 (2.0)
	Total current users	126 (52.5)	49 (81.7)	175 (58.3)
TOTAL		240 (100.0)	60 (100.0)	300 (100.0)

2. PATTERN OF DRUG USE

The current users of drugs in our samples constituted 58.3 per cent. Of the 175 current users 51.4 per cent used only tobacco or alcohol or both while 49.6 per cent used other drugs with or without tobacco and/or alcohol. If alcohol and tobacco are excluded from drugs, the extent of drug use in hostel inmates (current users) comes to only 12 per cent. In the 1976 study of drug use among college/university students the extent of drug use (excluding alcohol and tobacco) was reported 7.5 per cent only.²

If only current users (i.e. 175 hostel inmates) are taken and those who use only alcohol and/or tobacco are excluded, the extent of drug use is found to be 36 per cent. If those who use only painkillers (to relieve pain) are also excluded the extent of drug use is 12 per cent. These figures clearly show that drug abuse (using drugs without medical advice) in the sample is 21 per cent. It indicates that drug abuse is not very widespread among students (including hostel inmates) in our society, and that drug consumption has not yet acquired the dimension of a social problem affecting large sections of younger generation.

2. R. Ahuja, op.cit., p. 22.

3. DRUG USE AND COURSE BACKGROUND

The classification of drug user (both past and current users) in the sample according to course of study background (faculty wise) leads to very interesting findings on analysis of our data.

TABLE 3.2
DRUG USERS WITH THEIR COURSE BACKGROUND
(in the sample)

S.NO.	COURSE OF STUDY	NO. OF RESPONDENTS	PAST- USERS	CURRENT- USERS	PAST + CURRENT USERS	PERCENTAGE OF COL. 3
1.	SCIENCE	44	8	13	21	47.7
2.	SOCIAL SCIENCES	21	5	10	15	71.4
3.	ARTS	15	4	6	10	66.7
4.	COMMERCE	30	6	15	21	70.0
5.	LAW	5	0	4	4	80.0
6.	MEDICINE	35	7	15	22	62.9
7.	ENGINEERING	150	9	112	121	80.7
TOTAL		300	39	175	214	

Drugs were found to be used most by Engineering students, closely followed by Law students ; Social Sciences, Commerce, Arts and Medical students ranking third, fourth, fifth and sixth in descending order. In the total sample Science students formed 14.7 per cent while drug users among them were 47.7 per cent, Social Sciences students were 7 per cent in the sample while drug users among them formed 71.4 per cent. For Arts, Commerce, Law, Medical and Engineering students these percentages were 5.0, 10.0, 1.7, 11.7 and 50.0, 66.7, 70.0, 80.0, 62.9 and 80.7 respectively.

Current drug users among students with different course backgrounds were found as 29.5 per cent (Science), 47.7 per cent (Social Sciences), 40.0 per cent (Arts), 50.0 per cent (Commerce), 80 per cent (Law), 42.0 per cent (Medical) and 74.1 per cent (Engineering) of their respective numbers in the sample.

If we take total current users (175), the number and percentages of drug users with different course backgrounds among them are displayed in Table 3.3.

TABLE 3.3
CURRENT DRUG USERS WITH THEIR COURSE BACKGROUND

S.NO.	COURSE OF STUDY	PERCENT OF TOTAL SAMPLE	CURRENT USERS NO.	PERCENT OF TOTAL CURRENT USERS
1.	SCIENCE	14	13	7.4
2.	SOCIAL SCIENCE	8	10	5.7
3.	ARTS	5	6	3.4
4.	COMMERCE	10	15	8.6
5.	LAW	1.3	4	2.3
6.	MEDICINE	11.7	15	8.6
7.	ENGINEERING	50.0	112	64.0
TOTAL		300	175	100.0

Current drug users with their course background in relation to their respective numbers in the sample give the correct picture for purposes of comparison. Highest percentage of Law students (80.0) was found using drugs currently. Next come Engineering students with 74.1 per cent users, third came Commerce students with 50.0 per cent users. Fourth in descending order stood Social Sciences

students with 47.7 per cent users and fifth in descending order stood Medical students with 42.9 per cent users. Arts students with 40.0 per cent and Science students with 29.5 per cent users ranked sixth and seventh respectively.

These findings do not support the common notion that the highest prevalence of drugs exists among Medical students because of their knowledge of and accessibility to drugs. Availability of or accessibility to drugs does not seem to be very important in drug abuse. Studies by Lindesmith³, Lawrie⁴ and Nowlis⁵ in the United States and by Ahuja and others in multicentred national empirical surveys of College and University students in 1976 and 1986 have also shown that people who abuse drugs or become drug addicts do so because of other factors including personality factors rather than the availability of drugs. It is these

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3. Alfred Lindesmith, **The Addict**, Gold Medal Books, New York, 1963
 4. Peter Lawrie, **Drugs : Medical psychological and Social facts**, Penguin Books, Maryland.
 5. Helen H. Nowlis, **Drugs on the College Campus**, Anchor Books, New York, 1969.
 6. D. Mohan etc., **Current Research in Drug Abuse in India**, & Unpublished Report of 1986 National Survey of Drug use among College/University students.

factors that seem to be really important. This also helps us in hypothesising that consumption of drugs differs with respect to professional and non-professional courses of studies.⁷

4. DRUG USE RELATED TO PROFESSIONAL AND NON-PROFESSIONAL COURSES

TABLE 3.4

COURSE OFFERED (PROFESSIONAL OR NON-PROFESSIONAL)
BY THE DRUG USERS IN THE SAMPLE

Course offered	Total students in the sample	Current users
Professional	185	127
% of sample/CU	(61.7)	(72.6)
Non-professional	115	48
% of sample/cu	(38.3)	(27.4)
TOTAL	300	175
	(100.0)	(100.0)

72.6 per cent of the current drug users were students who had offered professional courses, only 27.4 per cent of the current drug users belonged to the category offering non-professional courses. It is pertinent to remember here that in our study Engineering faculty students

far outnumbered the students of medical faculty. 58.3 per cent of the total sample used drugs currently. Out of which Engineering students accounted for 37.3 per cent whereas Medical students only 5 per cent. Thus, in comparison with Medical students the prevalence of drug use among Engineering students was much wider.

Even a cursory look at Table 3.2 figures does not justify the hypothesis that drug use is equally popular among both types of students i.e. those who offer professional course. (Medicine and Engineering) and those who offer non-professional courses (Science, Social Sciences, Arts, Commerce and Law).

5. NATURE OF DRUGS USED

What are the favourite drugs used by hostel inmates ? Our study shows that tobacco and alcohol were the most widely used substances. Out of 175 current users in the sample, 90 (51.34 per cent) used alcohol (wine, beer, whisky etc.) and/or tobacco (cigarette, cigar, bidi, tobacco eatables). Those who used alcohol and/or tobacco plus other drugs formed 36.6 per cent of the current users. This alcohol and/or tobacco users constituted the largest majority of the current users (i.e. 88 per cent). Users

using other drugs like depressants, narcotics stimulants and psychoelic drugs etc. constituted only 12.0 per cent of the current users (see Table 3.1)

Of the 63 current users using drugs other than alcohol and tobacco, 50.83 per cent used depressants, 10.3 per cent stimulants, 26.2 per cent narcotics and hallucinogens. Among depressants, the most popular were painkillers (32.0 per cent) followed by tranquilisers (16.6 per cent and barbiturates (2.3 per cent). Amphetamine, a stimulant, was used by 10.3 per cent hostel inmates. Among narcotics, cannabis was taken by 20.0 per cent, heroin, cocaine and pethidine by 4.0 per cent and opium 1.2 per cent. Only 2.2 per cent hostellers used hallucinogens, particularly LSD.

Those who used drugs other than alcohol and tobacco, were sub-divided into two sub-categories (a) those using more than one drug. 8.57 per cent of current users used only one drug whereas among them users of more than one drug were 3.42 per cent only. This shows that 'real' drug abuse problem among hostel inmates is not at all serious.

The data compiled from our questionnaires and interview schedules shows that drugs (excluding alcohol and tobacco) which were mostly used by the hostel inmates in our

sample were those depressants which relieve pain, depress drives, reduce tension and give a sense of calm and contentment. The stimulants which produce excitement and alertness and give 'kicks', were taken only by per cent of drug users. narcotics and hallucinogens which give feelings of pleasure and strength, were taken by per cent.

It could also be maintained that nearly 75 per cent drug users took only 'recreational drugs' (like alcohol and tobacco) for relaxation, fun and for getting away from the stresses and strains of life. Both alcohol and tobacco are socially accepted and considered less harmful. About 37 per cent drug users took drugs other than alcohol and tobacco also but more than two - thirds of them confessed using 'medically prescribed drugs to alleviate physical ills, and only 12 per cent took drugs to escape from the reality of the external or the internal world.

6. DRUG USE BY SEX

The incidence of drug use on the basis of sex shows that fewer girls used drugs than boys. Among 39 past users (13.3 per cent of the sample) only 5 were girls, constituting only 8.33 per cent of the female component of the sample. The male past users were 34 i.e. 14.2 per cent of 240 male hostelers who figured in the sample. Out of 175

current drug users 25 girls (41.7 per cent, of total girls in the sample) took alcohol or tobacco or both and 20 girls (33.3 per cent) took tobacco and/or alcohol plus drugs compared to 65 boys (27 per cent of total boys in the sample) who took alcohol and/or tobacco and 44 boys (18.3 per cent) who took alcohol and/or tobacco plus drugs. In respect of the use of one drug other than alcohol and/or tobacco by 15 hostel inmates the ratio of males to females was 4:1 and as regards the use of more than one drug other than alcohol and/or tobacco this ratio was 5:1. This shows that male users of one drug were 4 times of such female users and the use of more than one drug was prevalent five times more among males compared to females' (see Table 3.1)

If we take current users only and analyse the incidence of drug use on the basis of sex, we find that out of 60 girls (in the sample) 49 (81.7 per cent) were found using tobacco, alcohol and other drugs whereas only 126 out of 240 males (in the sample), i.e. 52.5 per cent were using the above substances. 41.7 per cent of girls were using tobacco or alcohol or both, 33.3 per cent used tobacco or alcohol or both plus drugs and 6.7 per cent used one or more drugs other than alcohol and tobacco. These figures point to a disturbing tendency among female hostelers towards using

more 'recreational' as well as non-creational drugs compared with both types of drugs used by boys. Alcohol and tobacco use was found more prevalent among girls compared to boys (see Table 3.1).

TABLE 3.5
SEX-WISE DRUG USE AMONG CURRENT USERS

S.No.	SUBSTANCE	MALE	%AGE	FEMALE	%AGE	TOTAL	%AGE
1.	ALCOHOL	54	42.7	10	20.4	64	36.6
2.	TOBACCO	36	28.6	12	24.5	48	27.4
3.	<u>SEDATIVES</u>						
i)	BARBITURATES	-	-	-	-	-	-
ii)	TRANQUILISERS	12	9.5	3	6.1	15	8.6
iii)	PAINKILLERS	9	7.2	23	47.0	32	18.3
4.	<u>STIMULANTS</u>						
i)	AMPHETAMINES	3	2.4	1	2.0	4	2.3
5.	<u>NARCOTICS</u>						
i)	OPIUM	-	-	-	-	-	-
ii)	CANNABIS	10	7.9	0	0.0	10	5.7
iii)	HEROIN	1	0.8	0	0.0	1	0.6
iv)	PETHIDINE	-	-	-	-	-	-
v)	MORPHINE	-	-	-	-	-	-
6.	<u>HATHEINOGENS</u>						
i)	L.S.D.	1	0.8	0	0.0	1	0.06
TOTAL		126	100.0	49	100.0	175	100.0

The ratio of male to female users varied considerably for different drugs (see Table 3.5). The incidence of current use of more socially acceptable drugs like alcohol and tobacco was found quite high among both the sexes. 42.85 per cent of males and 20.4 per cent females were found drinking alcohol currently. Both of them together formed 36.6 per cent of current drug users. The incidence of tobacco use among male inmates was slightly higher (28.6 per cent) compared with that of girls (24.5 per cent). Both sexes using tobacco constituted 27.4 per cent of the current drug users. Among sedatives painkillers were more widely prevalent among female inmates. 47 per cent of them used painkillers, but only 7.2 per cent of boys used them taking current drug users, 18.3 per cent out of them used painkillers. Only 8.6 per cent of current users were taking tranquilisers. (6.1 per cent women and 9.5 per cent men). No boy or girl was found using barbiturates as sedatives. As regards stimulants only 2.3 per cent of current users used amphetamines (boys 2.4, girls 2.0 per cent).

Of the current drug users only 6.3 per cent used narcotics. 7.9 per cent of boys were using cannabis and only 0.8 per cent were using heroin. The incidence of usage of dangerous drugs like hallucinogens was almost absent. A

negligible 0.8 per cent of boys used L.S.D. Surprisingly no girl inmate of any hostel was found using narcotics or hallucinogens.

This shows that psychoactive drugs (painkillers and tranquilisers etc.) likely to be given on prescription basis, were used more often both by boys and girls as compared to the insignificant (or scarce) use of narcotics (opium, heroin, morphine, pethidine, hashish) and L.S.D. Boys tended to experiment with "recreational drugs" (alcohol and tobacco) more than did the girls.

A very small number of boys were found using cannabis and still smaller number of them were using heroin. Use of opium, pethidine, morphine and cocaine was found almost absent among both the sexes. They revealed that they shudder at the very idea of taking these drugs causing serious deleterious effects on human body and mind.

7. FREQUENCY OF DRUG USAGE

The frequency with which different drugs were used by the 'current users' in the sample suggested that a small number of hostel inmates were involved in chronic use of drugs and a large number primarily with experimentation.

Out of 175 current users, 7.4 per cent were those who took drugs including alcohol and tobacco more than six times a week, i.e. almost daily. Excluding alcohol and tobacco, this frequency in respect of depressants, narcotics and other drugs was associated with only 2.9 per cent of current users. We can label these chronic drug users as 'addicts' or 'dependents' who could not live without drugs. Those who were taking drugs less often than once a week or a fortnight or a month were experimenters. They accounted for 70.8 per cent of current users - 21.7 per cent were 'regulars' who took drugs daily or several times a week. Among 64 drinkers (alcohol users), 36.7 per cent took alcohol less often than once a month, 18.0 per cent took once a month, 15.6 per cent took once a week, 12.5 per cent took several times a week, 9.6 per cent took daily and 7.8 per cent were addicts i.e. those who could not live without alcohol.

A similar relationship held for smoking or tobacco consumption in any way, as out of 48 smokers only 40 per cent smoked occasionally (i.e. once in several months or at the most once a month), 18.33 per cent smoked once a month, 12.5 per cent once a week and 10.42 per cent several times a week, 10.42 per cent almost daily. Only 8.33 per cent smokers were chronically habituated i.e. they could hardly live without smoking.

Out of 63 users in the sample who took drugs other than alcohol and/or tobacco, only 6.4 per cent were addicts, 22.2 per cent were regulars (who took drugs daily or several times a week) and 71.4 per cent were experimenters (who took drugs once a week or once a month or less often than once a month). These figures are given in a simplified form in Table 3.6.

Painkillers among 'regulars' accounted for 24 per cent but 'experimenters' accounted for 75 per cent. Tranquillisers had 13.3 per cent addicts. Only 10 per cent of narcotic (cannabis) users were 'addicts', 20 per cent were 'regulars' whereas 70 per cent cannabis users were merely 'experimenters'. In respect of other drugs, 16.7 per cent of their users were addicts, 33.4 per cent 'regulars' and 60 per cent 'experimenters'. Thus compared to addicts of other drugs, 'regulars' were just the double and 'experimenters' three times as many. If we take all the drugs including alcohol, tobacco, depressants, narcotics and other drugs, we find that in no case 'addicts', or regular users outnumbered 'experimenters'.

Let us now analyse the frequency of drug taking by the 175 current users in the sample. The analysis showed that 10.3 per cent took only one drug, 32 per cent two

TABLE - 3.6

DRUG WISE FREQUENCY (TIMES PER WEEK) OF USING DRUGS BY HOSTEL INMATES

N = 175

S.No.	Substances	-1	1+	+3	+5	+6	N
1.	Alcohol	35 (54.7)	10 (15.6)	8 (12.5)	6 (9.4)	5 (7.8)	64 (100.0)
2.	Tobacco	28 (58.33)	6 (12.5)	5 (10.42)	5 (10.42)	4 (8.33)	48 (100.0)
3.	<u>Depressants</u>						
(i)	Pain-killers	20 (62.5)	4 (12.5)	5 (15.6)	3 (9.4)	-	32 (100.0)
(ii)	Tranquilisers	8 (53.33)	3 (20.0)	2 (13.33)	-	2 (13.33)	15 (100.0)
4.	<u>Narcotics</u>						
(i)	Cannabis	5 (50.0)	2 (20.0)	1 (10.0)	1 (10.0)	1 (10.0)	10 (100.0)
5.	Other drugs	2 (33.33)	1 (16.7)	1 (16.7)	1 (16.7)	1 (16.7)	6 (100.0)
<hr/>							
TOTAL		98 (56.0)	26 (14.8)	22 (12.6)	16 (9.1)	13 (7.4)	175 (100.0)

drugs, 27 per cent three drugs and 30.7 per cent four or more drugs. Of the 7.4 per cent 'addicts' 27 per cent took two drugs, 29 per cent three drugs and 43 per cent four or more drugs. Of the 21.7 'regulars' 60 per cent took three or less drugs, while of the 70.8 per cent 'experimenters' 75 per cent took less than three drugs, mostly alcohol, tobacco and painkillers and tranquilisers.

Thus it can reasonably be concluded that multiple drug use is the more familiar pattern among all the three groups of drug takers. However, both among the 'regulars' and 'addicts' this pattern is more sharply defined. That is, the tendency towards multiple drug use increases with the increase in frequency of drug use. Those who use depressants, stimulants narcotics and/or hallucinogens drugs also drink wine and smoke cigarettes, bidis or consume tobacco eatables (gutakas).

8. SEX-WISE FREQUENCY OF DRUG USE

If the frequency of drug use among boys is compared with that of girls, we find that the female users of alcohol, tobacco, painkillers, tranquilisers cannabis and other drugs showed lesser frequency of those drugs than male users. Between 70 to 80 per cent of women users took these drugs only once a month, or once or twice a week. Only

26.1 per cent girls were found using painkillers regularly, i.e. 3 to 5 times a week. Only 8.3 per cent girls were found smoking cigarettes daily, similarly 8.7 per cent girls were badly habituated to take painkillers. They took them regularly. Boys were using all the drugs - recreational, sedatives and narcotics and other drugs much more frequently compared to girls. Both regular and chronic users among boys far outnumbered the girls. This difference (between male and female users in the main sample) is shown in Table 3.7.

9. QUANTITY OF DRUG USE

As regards the quantity of drugs used by hostel inmates, in the case of alcohol, tobacco, painkillers and tranquilisers, the dose taken at the time of first use was very small but with the passage of time, it went on increasing. In the case of other drugs, however, the dose remained almost the same at the time of the last use as it was at the time of first use. For example, 64 current alcohol drinkers in the sample 70.3 per cent had taken on peg, 20.3 per cent two to three pegs and 9.4 per cent four or more pegs at the time of its first use, 33 per cent took one peg, 55.6 per cent two to three pegs and 11.4 per cent four or more pegs at the time of its last use.

DRUGWISE FREQUENCY (TIMES PER WEEK) OF USING DRUGS BY DRUG TAKERS IN THE SAMPLE

N = 175

S.No. Substance	1+			11			N		
	M	F	T	M	F	T	M	F	T
1. Alcohol	8 (14.8)	2 (20.0)	10 (15.62)	30 (55.5)	5 (50.0)	35 (54.7)	54 (100)	10 (100)	64 (100)
2. Tobacco	5 (13.9)	1 (8.3)	06 (12.5)	20 (55.6)	8 (66.7)	28 (58.3)	36 (100)	12 (100)	48 (100)
3. <u>Depressants</u>									
i) Painkillers	1 (11.1)	3 (13.0)	04 (12.5)	06 (66.7)	14 (60.9)	20 (62.5)	09 (100)	23 (100)	32 (100)
ii) Tranquillisers	2 (16.7)	1 (33.33)	03 (20.0)	06 (50.0)	02 (66.7)	08 (53.33)	12 (100)	03 (100)	15 (100)
4. <u>Narcotics</u>									
i) Cannabis	2 (20.0)	-	02 (50.0)	5 -	-	5 (50.0)	10 (100)	-	10 (100)
5. Other drugs	1 (20.0)	-	01 (16.66)	1 (20.0)	1 (100.0)	2 (33.33)	5 (100)	1 (100)	06 (100)
TOTAL	19	7	26	68	30	98	126	49	175

S.No.	Substance	6+			5+			3+		
		M	F	T	M	F	T	M	F	T
1.	Alcohol	5 (9.3)	-	5 (7.8)	6 11.0)	-	6 (9.4)	5 (9.3)	3 (30.0)	8 (12.5)
2.	Tobacco	3 (8.3)	1 (8.3)	4 (8.3)	5 (13.9)	-	5 (10.4)	3 (8.3)	2 (16.7)	5 (10.5)
3.	Painkillers	-	-	-	1 (11.1)	2 (8.7)	3 (9.4)	1 (11.1)	4 (17.4)	5 (15.6)
4.	Tranquilisers	2 (16.7)	-	2 (13.33)	-	-	-	2 (16.6)	-	2 (13.33)
5.	Cannabis	1 (10.0)	-	1 (10.0)	1 (10.0)	-	1 (10.0)	1 (10.0)	-	1 (10.00)
6.	Other drugs	1 (20.0)	-	1 (16.66)	1 (20.0)	-	1 (16.66)	1 (20.0)	-	1 (16.66)
TOTAL		12	1	13	14	2	16	13	9	22

In the case of tobacco, out of 48 tobacco users 70.8 per cent smoked one cigarette (or bidi), 20.9 per cent two to three cigarettes and 8.3 per cent four or more cigarettes at the time of first use, while smoking of cigarettes increased with the passage of time. Only 40 per cent smoked one cigarette 35 per cent two to three cigarettes and 2.5 per cent four or more cigarettes at the time of last use.

In the case of painkillers, 75 per cent had taken pill and 13.3 per cent two or more pills at the time of first use in comparison to 33.4 per cent having taken one pill and 66.6 per cent two or more pills at the time of last use. 13.3 per cent users of painkillers were found to be addicts ; at the time of last use, many of them consumed more than 3 pills daily. In the case of barbiturates, amphetamines, cannabis (marijuana, hashish), morphine, pethidine and L.S.D. 90 to 94 per cent current users had taken only one dose at the time of its first use while 88 to 93 per cent had taken almost the same dose of these drugs at the time of their last use.

The above figures of intake of quantity of drugs show that 'expanders' (like L.S.D.) and 'contractibles' (like narcotics) drugs do not attract much following and that only 'downers' drugs which do not cause 'ill effects' are gaining wide use among hostel inmates of colleges and

A Youth injecting Drug into his friend's arm.



the University. However, it could be emphasized that there is something disturbing in these trends to cause concern to the general public, educationists, social workers and administrators. The gradual increase in the fascination of our youth to drugs needs immediate ameliorative measures.

10. METHOD OF DRUG USE

How are the drugs taken ? A large number of drugs (about 96.2 per cent in the sample) were those which were taken by mouth and/or by smoking. In less than 4 per cent cases in the sample, they were taken by injection. Morphine and/or painkillers were the drugs mostly self-administered by injection.

11. CONCLUSIONS

What can be concluded on the basis of above analysis ? The conclusions are : (1) hostel inmates generally have a fancy for recreational drugs which do not produce any toxic hangovers and for which no prohibition or social sanction against their use exists. Only 7.4 per cent of current users in the sample were found to be addicts of all drugs including alcohol and tobacco. Only 4 out of 13 addicts in the sample i.e. 1.3 per cent of sampled hostel inmates or 2.3 per cent of current drug takers) were found prisoners of their insatiable craving and made their pursuit

of the drug a course of tragedy and pain. They presented themselves as a pathetic group and appeared resigned to their unfortunate lot.

Psychiatrists traditionally proclaim drug addicts as inmates and irrational. They (addicts) are said to have a compulsion to avoid responsibility. Sociologists built their entire theoretical edifice that addiction (this is often stretched to include all illegal drugs use) is a "retroacist" adaptation to the problem of social adjustment and that the addict is attracted to his drug because he is a "double failure"⁸. According to Goode, these views have built into them the biased assumption that to conform to society's expectations is 'normal' and that to do otherwise requires an explanation invoking a pathology or dysfunction of some kind.⁹ However, the addict, looks at his behaviour from the perspective of addict sub-culture and judges his behaviour radically differently. It would not be justifiable to label addicts as "hopeless failures". They do retreat into a shade of dreamy idleness, a euphoric temporary death but this state of oblivion does, indeed, typify a certain

8. Cloward and Ohlin, **Delinquency and Opportunity**, Free Press, New York, 1960.

9. Erich Goode, **Drugs in American Society**, p. 177.

temporal slice of the addict's day. Some sociologists and anthropologists have discovered that the above temporary state of the addict does not take him altogether out of contact with the world. Rather addiction "plunges the newly recruited addict into abrasive contact with the world."¹⁰ - The rest of the time they are actively, aggressively pursuing their challenging activities. Our study does not, however, provide sufficient evidence to concur or disagree with the above view. Perhaps, scientifically less authentic on this point are some of the recent studies on drug abuse among Indian youth."¹¹ They seem to have indulged in rhetories. The reality in their case has either been confused or obfuscated. The conclusions of our study largely agree with those of Dr. Ahuja's survey of college/university students in Jaipur city conducted in 1986 (repeat survey of 1976). He maintains that non-alcoholic drug use is not a frequent activity among these students. Tobacco and alcohol

10. Lindesmith and Gangon, **Anomie and Drug Addiction in Anomie and Deviant Behaviour**, (ed. Marshall B. Clinard, Free Press ; New York, 1964 pp. 158-188.

11.(i) Bhim Sain, **Drug Danger and Social Behaviour**.
 (ii) T. Kapur, **Drug Epidemic among Indian Youth**.
 (iii) Beena Menon, **Drugs, The Evil Addiction**
 (iv) S.K. Ghosh, **The Traffic in Narcotics and Drug Addiction**.

are used more frequently and their incidence is also higher compared to both the frequency and incidence of use of sedative and narcotic drugs and hallucinogens among them. There is little reason, therefore, to see a "drug-epidemic" or "drug rampage" among the student youth in our society.¹²

Although drugs consumed by a large number of hostel inmates are not addictive, the possibility of developing psychological dependence is high. Besides, the taking of these drugs is bound to affect the socially acceptable values of youth, like hard work, courage and struggle for accomplishing challenging tasks. There is sneaking danger in the susceptibility of youngsters to discarding these age-old tested values and objectives and to disregarding old goals and means as irrelevant, for then a vast majority of our educated youth - the most valuable asset of the nation-will have to face the dilemma of directionlessness. It is, therefore, time to pay more attention to timid and emotionally immature college/university students who get into trouble with drugs, even if they are recreational".¹³

12. **The Drug use among College/University Students' in Jaipur City, 1987.** An unpublished report, p. 35.

13. **R. Ahuja, Sociology of Youth Subculture, p. 33.**

CHAPTER - IV

SOCIAL STRUCTURE AND DRUG USE

CHAPTER - IV

SOCIAL STRUCTURE AND DRUG USE

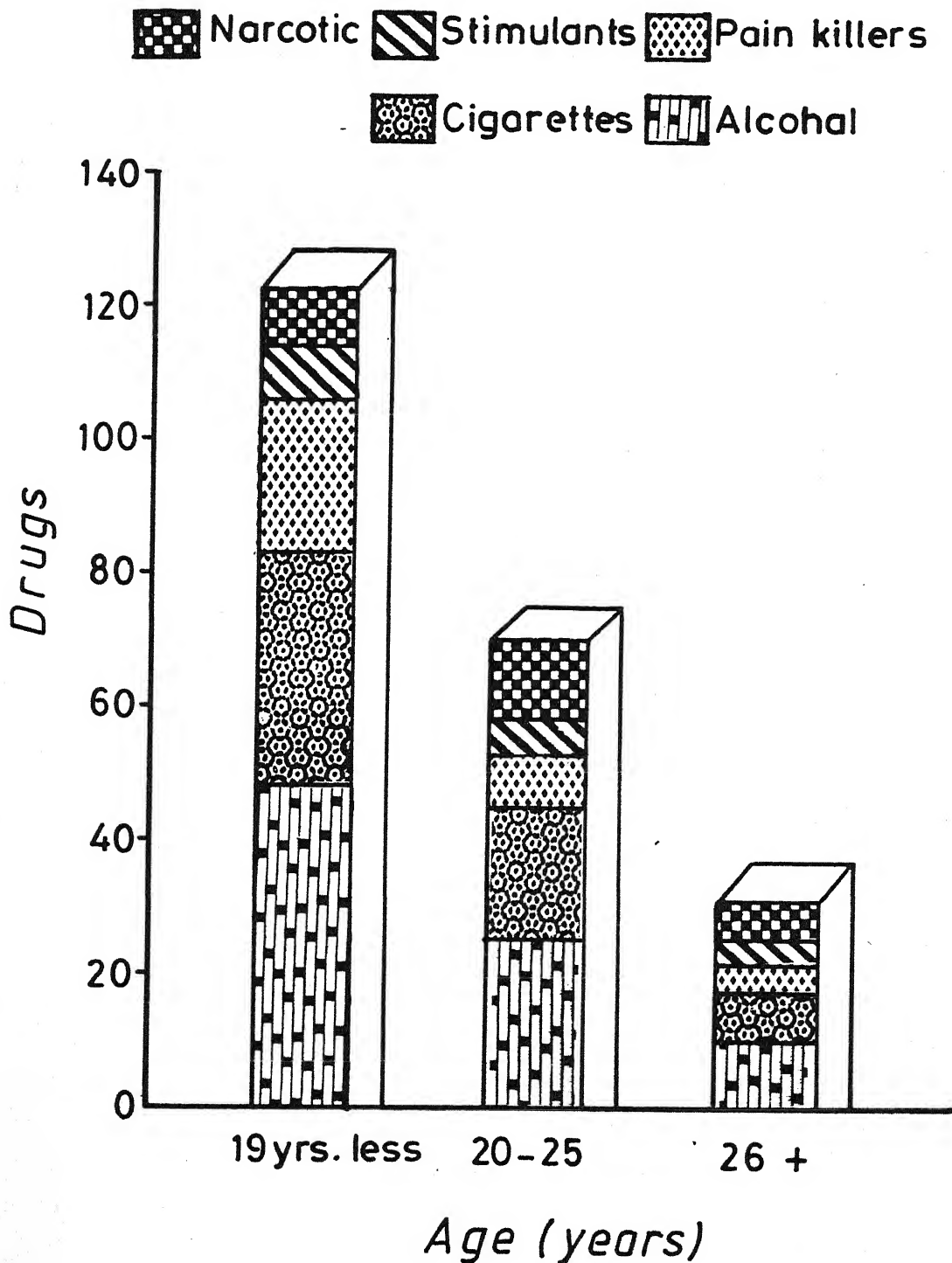
Is there any association between the use of drugs and various socio-demographic variables which may help in conceptualising the research findings about drug use ? We have already proposed to analyse the relationship between social structure and drug use. This is one of the important dimensions of our study. We have to look at a set of socio-economic attributes of hostel inmates. In spite of common status, common roles and shared values students (including those residing in college/university hostels) in our society are variously differentiated into social strata and also have their distinctive social and cultural perceptions and interests. Students with different personalities and different environmental backgrounds are variously exposed to the hazards of aberrant behaviour. This is obvious from our observations. This premise directs us to recognise that different pressures operate upon students differently located in the social-economic and educational structures in respect of their engaging in the deviant behaviour of using drugs. And consequently they are adversely subject to the effects and hazards of drug use. All the sampled hostelers may not be uniformly vulnerable to the detrimental consequences of drug abuse.

What are the social attributes of the drug users ? In order to understand the place of drug using students in the social structure, it is necessary to analyse their social and economic background. We will examine this in terms of some selected variables like age, sex, education, type of school, medium of instruction, academic interest, extra-curricular/co-curricular activities, income group of drug users' family, residence (rural, semi-urban, urban), caste and religion and configuration of these variables a different pattern of use and abuse of drug emerges. Our effort is to understand the nature and form of the social terrain from which recruitment to drug using deviant behaviour is taking place. It is generally believed that 'open' social milieu has greater potential for aberrant behaviour compared to that of closed social milieu. A word of caution is necessary here. These terms 'open' and 'closed' need not be interpreted within the tight frame of familiar jargon.

1. AGE AND DRUG USE

If we classify all the current drug users (in the sample) into three age groups, i.e. very young (19 years or less), young (20-25 years) and not so young (26 years and above), we find that among the users of alcohol, cigarettes, depressants and

Age wise and Drugwise Current Users



stimulants, 53 to 58 per cent students were very young, 26 to 30 per cent were young and 12 to 21 per cent were not so young. In contrast, among the users of painkillers, 67.5 per cent were very young, 22.5 per cent were young and 10 per cent were not so young. Among narcotics users, 40.9 per cent were very young, 31.8 per cent were young and 27.3 per cent were not so young.

TABLE 4.1

AGEWISE AND DRUGWISE CURRENT USERS

N-175

S.No.	Drug	Very young (19 and below)	Young (20 - 25)	Not so young (26 & above)
1.	Alcohol	48 (57.8)	25 (30.1)	10 (12.1)
2.	Cigarettes	35 (56.5)	20 (32.2)	7 (11.3)
3.	Painkillers	23 (67.5)	13 (22.5)	4 (10.0)
4.	Depressants & Stimulants	10 (52.6)	5 (26.4)	4 (21.0)
5.	Narcotics	9 (40.9)	7 (31.8)	6 (27.3)
TOTAL (N)		125	70	31

Table value : $x^2 = .05\%$; $x^2 = 0.05$
 $= 15.507$; $\phi = 20.090$

x^2 table value

Null hypothesis disapproved

Comparing the age of current users with non-users and past-users, it was found that against 55.7 per cent very young current users, 10.0 per cent were very young past users and 34.3 per cent very young non-users. Against 49.1 per cent young current users there were 20.0 per cent young past users and 30.9 per cent young non-users. Among the not so young hostelers, there were 24.8 per cent non-users, 8.8 per cent past users and 66.3 per cent current users. Hence, the durg addicts of age group of 26-27 are most currently using at.

TABLE 4.2

AGE OF USERS AND NON-USERS

S.No.	Age-Group	Non-Users	Past-Users	Current Users	Total
1.	16 - 17	15 (38.5)	3 (7.7)	21 (53.8)	39 (100.0)
2.	18 - 19	12 (30.0)	5 (12.5)	23 (57.5)	40 (100.0)
3.	20 - 21	18 (38.3)	7 (14.9)	22 (46.8)	47 (100.0)
4.	22 - 23	12 (35.3)	6 (17.6)	16 (47.1)	34 (100.0)
5.	24 - 25	4 (10.3)	9 (23.1)	26 (66.6)	39 (100.0)

TABLE 4.2 CONTD.

S.No.	Age Group	Non-Users	Past-Users	Current Users	Total
6.	26 - 27	3 (10.0)	4 (13.3)	23 (76.7)	30 (100.0)
7.	28 - 29	9 (31.0)	3 (10.4)	17 (58.6)	29 (100.0)
8.	30 - 31	7 (35.0)	1 (5.0)	12 (60.0)	20 (100.0)
9.	Above 32	6 (27.3)	1 (4.5)	15 (58.2)	22 (100.0)
TOTAL		N = 86	N = 39	N = 175	N = 300

Taking all drugs together, it could be said that out of every 100 current users 54.8 were very young, 28.6 were young and 16.6 were not so young.

Chi-square test does not justify our null hypothesis that drug use does not vary with the age group. In fact, the lower is the age group, the greater is the use of drug, especially 'recreational drugs'. Use of narcotics and other hard drugs was found more prevalent among older students.

TABLE 4.3ASSOCIATION BETWEEN AGE GROUP AND DRUG USE

Age Group	Non-Users	Ever-Users	Total
1. Not so young	25 (24.7)	76 (75.30)	101 (100.0)
2. Young	34 (28.3)	86 (71.7)	120 (100.0)
3. Very young	27 (34.1)	52 (65.9)	79 (100.0)
TOTAL	N = 86	N = 214	N = 300

Among not so young, 75.3 per cent were ever users while non-users were 24.7 ; among the young, 71.7 per cent were ever users and 28.3 per cent were non-users. As against these two age groups, among the very young non-users were 34.1 per cent and ever-users were 65.9 per cent. This shows that the proportion of non-users tends to decline with the advance in age. The converse of this is also true. The proportion of ever-users tends to increase with the advance in age. These findings suggest that **drug use varies with the age-group**. However, they do not support the belief that 17-20 years age-group (or 20 years and below) could be identified as peak age group or the

most crucial age group in developing the habit of consuming drugs.¹

TABLE 4.4

ASSOCIATION BETWEEN AGE GROUP AND DRUG USE

Age Group	Non-User	Ever-Users	Total
Not so young	25	76	101
Young	34	86	120
Very young	27	52	79
TOTAL	N = 86	N = 214	N = 300

2. SEX AND DRUG USE

TABLE 4.5

SEX-WISE AND AGE-WISE DRUG USE IN THE SAMPLE

Age Group (in years)	EVER USERS		Total
	Female	Male	
Below 20	22 (17.4)	105 (82.6)	127 (100.0)
21 to 25	18 (37.5)	30 (62.5)	48 (100.0)
26 to 30	10 (33.3)	20 (66.7)	30 (100.0)
Above 30	4 (44.4)	5 (55.6)	9 (100.0)

As in the age group of 30 and above, males as well as females are drug addicts in high percentage, there is probability that they may continue and they may strengthen the habit.

Comparing the age of girls with boys, female users were found to be younger than the male users. In the age group of below 20 years, 82.6 per cent were boy users while 17.4 per cent were girl users ; in the age group of 21 to 25 years, 62.5 per cent users were boys while 37.5 per cent were girls users and in 26 to 30 years age group, the male drug users were just the double of the female users. In the above 30 years age group, 55.6 per cent were male users compared to 44.4 per cent female users.

Out of 54 female drug users, 22 (40.7 per cent) belonged to the most impressionable age, i.e. the very young age group (below 20 years), 18 girls (33.3 per cent) came from the 21-25 years age group, 18.5 per cent belonged to 26-30 years age group and only 7.5 per cent girl users came from the advanced age group of above 30 years. In comparison to girls the percentages of boy drug users in the above four groups were 65.6, 18.8, 12.5 and 3.1 respectively. This shows that largest proportion of girl drug users (40.7 per cent) belonged to the very young age group and the young age group (21 to 25 years) of girl

users was a close second (33.3 per cent). The 26-30 years age group and the above 30 years age group accounted for 18.5 and 7.5 per cent drug users respectively. The largest and lowest proportions of male users belonged to the very young and the above 30 years age groups. These findings further confirm the fact that both the boys and girls are most vulnerable to drug hazard in their most impressionable (or immature) age. With the advance in age, both them evidenced lower temptation to drug consumption. (See Table 4.5).

Chi-square list does not justify our null hypothesis that drug use does not vary with the age-group.

TABLE 4.6

SEX-WISE AND AGE-WISE DRUG USE IN THE SAMPLE

Age Group	EVER USERS				Female to male ratio approx.
	Female No.	% of total females	Male No.	% of total males	
Below 20	22	40.7	105	65.6	2 : 3.2
21 to 25	18	33.3	30	18.8	3.5 : 2
25 to 30	10	18.5	20	12.5	3 : 2
Above 30	4	7.5	5	3.1	2.4 : 1
TOTAL	54	100.0	160	100.0	

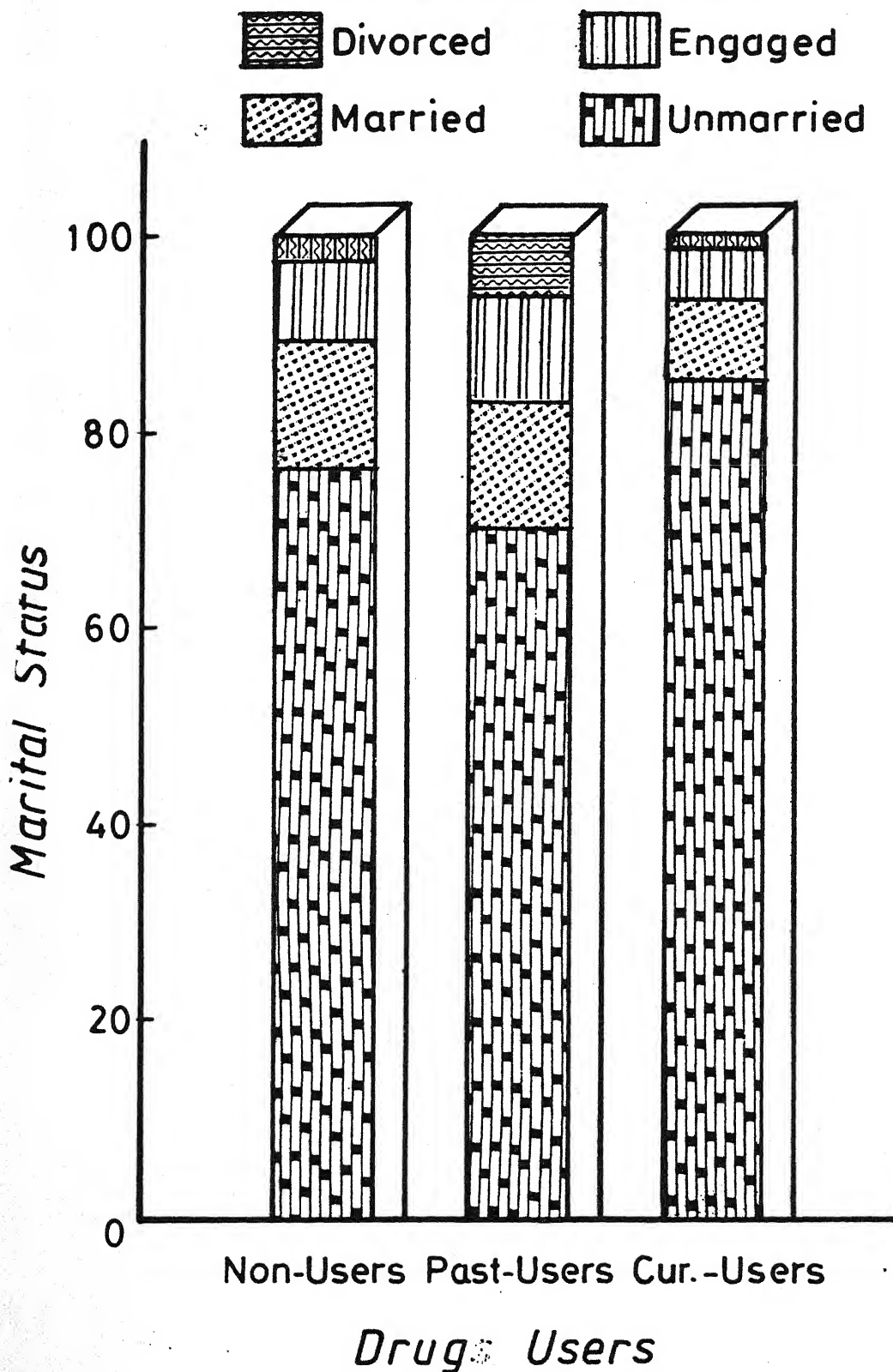
The female - male ratios given above clearly show that in the very young age group larger proportion of males used drugs compared to females, while in the rest of age groups the female drug users were above one and a half to two and a half times larger proportionately compared to boys. This comparatively higher consumption of drugs among the young and not so young girls could be due to increased use of painkillers by them, during menstruation. Or it might also be due to the intensifying anxieties born of the prospects of postponed marriages. Both psychiatrists and sociologists have reached similar conclusions in relation to association of drug use with sex and age. Also modernisation had its greater impact on the life style of both the sexes with the increase in the period of stay in the hostel.

TABLE 4.7

MARITAL STATUS AND DRUG USE

Marital status	Non-Users %	Past-Users %	Current Users %	Total of sample %
Unmarried	72.1	66.7	84.0	78.3
Married	18.6	15.4	10.3	13.3
Engaged	7.0	10.3	4.6	6.0
Divorced/ Widowed	2.3	7.7	1.1	2.4
GRAND TOTAL	N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)

Marital Status and Drug Use



Is there any association between drug use and marital status ? Of the non-users, past users and current users who accounted for 72.1, 66.7 and 84.0 per cent respectively, the portion of the married persons in the three sub-groups was 18.6, 15.4 and 10.3 respectively. The engaged persons in the three sub-groups were 7.0, 10.3 and 4.6 per cent respectively and the divorced/widowed were found 2.3, 7.7 and 1.1 per cent respectively. **These figures show that drug use does vary with the marital status.** The single/unmarried everusers constitute 80.8 per cent of drug users. The percentages of married, engaged and divorced, widows and widowers among the ever-users are 11.2, 5.6 and 2.4 per cent respectively. The decreasing tendency of drug use among married, engaged and widowed/divorced persons could be associated with the increasing sense of responsibility in these groups. A number of our respondents tacitly admitted that they were obliged to discard/refrain from drug using owing to persistent pursuation by their spouses or betrothed. This phenomenon should agree with the traditionally accepted principle that social responsibility and individual restraint are directly and positively correlated.

TABLE 4.8ASSOCIATION BETWEEN MARITAL STATUS AND DRUG USE

	Unmarried	Married	Total
Non-users	62	17	79
Ever-users	75	13	88
TOTAL	N = 137	N = 30	N = 167

Obtained value $\chi^2 = 13.343$

Table value $\chi^2 = 3.841$

Since χ^2 value is higher than the table value of χ^2 , it shows that the null hypothesis is justified. Drugwise does not range with marital status.

4. EDUCATION AND DRUG USE

(a) Class-wise drug use

The educational distribution of respondents in the sample showed that among 118 post-graduates, ever-users of drugs were 83.9 per cent compared to 63.2 per cent of under-graduate ever-users. Thus less under-graduate students were found using drugs compared to post-graduates. Among 182 under-graduates the non-users, past users and

current users were 36.9, 12.6 and 50.5 per cent respectively. Among 118 post-graduates, these percentages were 16.1, 13.6 and 70.3 respectively.

TABLE 4.9

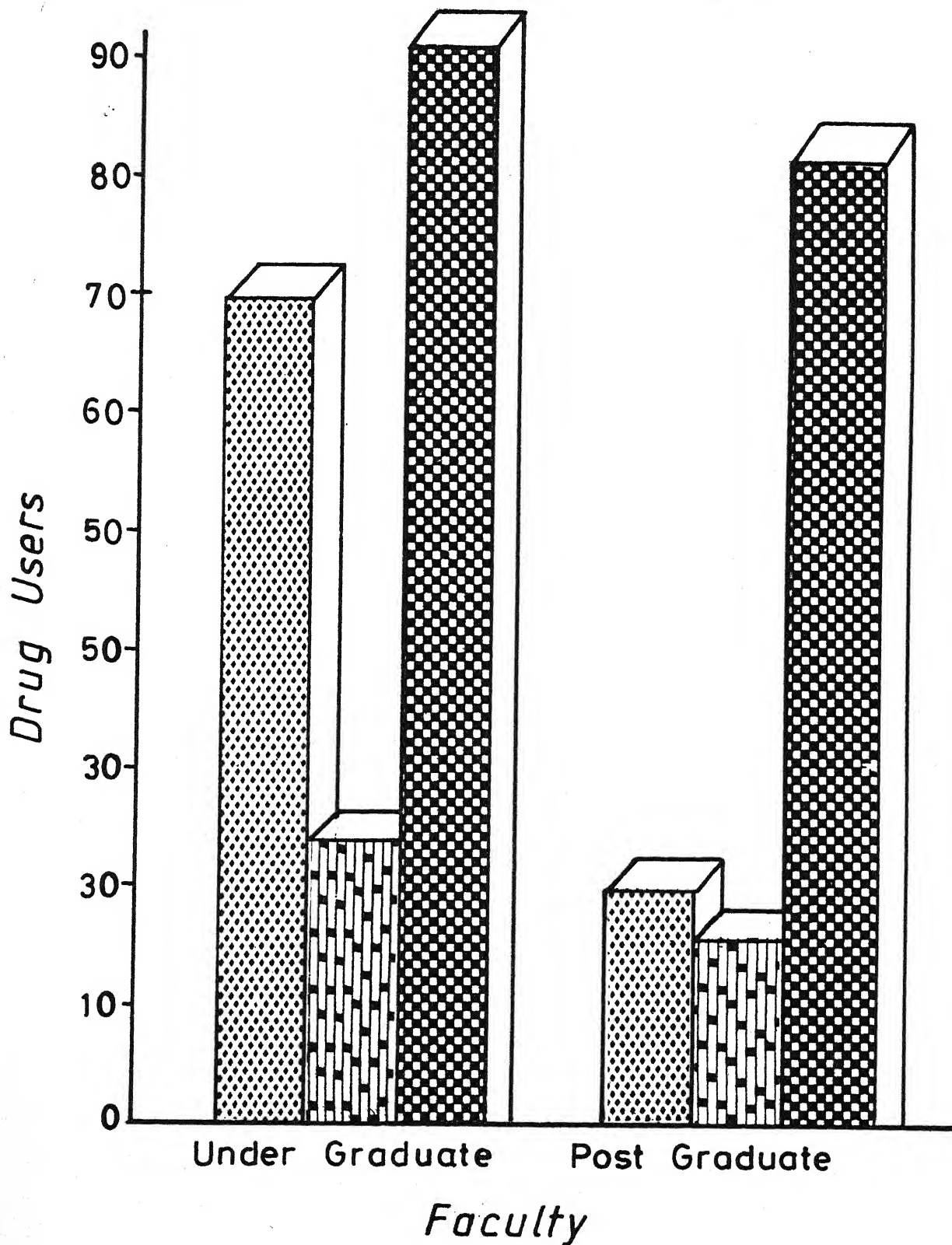
CLASS-WISE DRUG USE IN THE SAMPLE

S.NO.	CLASS OF STUDY WITH TOTAL NO. IN EACH	NON-USERS		PAST-USERS		CURRENT USERS		TOTAL PAST & CURRENT USERS	
		NO.	%AGE	NO.	%AGE	NO.	%AGE	NO.	%AGE
1.	UNDER-GRADUATE (182)	67 (36.9)		23 (12.6)		92 (50.5)		115 (63.2)	
2.	POST-GRADUATE (118)	19 (16.1)		16 (13.6)		83 (70.3)		99 (83.9)	
TOTAL (300)		86		39		175		214	

Now, if we calculate the percentage of ever-users among under-graduates and post-graduates in the sample 115 under-graduate of 300, i.e. 38.3 per cent were ever-users, and 99 post-graduate of 300, i.e. 33 per cent were ever-users. Compared to the proportion of under-graduates and that of post-graduates in the sample i.e. 60.7 per cent and 39.3 per cent respectively the ratio of under-graduates users and post-graduates users is about 3:4 as against their ratio in the sample i.e. 3 : 2

Classwise Drug Users

Non Users Past Users Ever Users



(approximately). This again suggests that there was higher incidence of drug use among the post-graduates compared to that in the under-graduates. Thus, there is a definite relationship between the class of study and the use of drugs (see Table 4.10)

TABLE 4.10

CLASS-WISE DRUG USE IN THE SAMPLE

Class	Ever-user	Non-user	Total
Under-graduate	115	67	182
Post-graduate	99	19	118
TOTAL	214	86	300

From the data of Table 4.10 we have to find out the statement association between class and drug use.

$$\begin{array}{rclcl}
 \text{Obtained value} & = & x^2 & = & 15 \\
 \text{Table value} & = & x^2 & = & 3.841 \\
 \text{df} & = & 1 & & p = .05
 \end{array}$$

Since the table value of x^2 is lower than the obtained value of x^2 , it shows that the null hypothesis that drug use is not dependent on class of study is found to be incorrect. It could therefore stand that the use of drug does range with the undergraduate and post-graduate

Comparing the difference in the education level of drug users on the basis of sex, it was found that 89.2 per cent were females and 56.6 per cent males among under-graduates compared to 91.3 per cent females and 82.1 per cent males among the post-graduates. (See Table 4.11).

TABLE 4.11

CLASS-WISE AND SEX-WISE DRUG USE

S.NO.	CLASS OF STUDY WITH NO. OF STUDENTS	NON-USERS		PAST-USERS		CURRENT USERS		PAST USERS + CURRENT USERS	
		M	F	M	F	M	F	M	F
1.	UNDER-GRADUATES (182)	63	4	20	3	62	30	82 (56.6)	33 (89.2)
2.	POST-GRADUATES (118)	17	2	14	2	64	19	78 82.1)	21 (91.3)
TOTAL	300	80	6	34	5	126	49	160	54

Out of 182 under-graduates males and females were 145 (79.7 per cent) and 37 (20.3 per cent) respectively, i.e. in about 4 : 1 ratio, while the ever-users among under-graduates males and females were 82 (56.6 per cent) and 33 (89.2 per cent), i.e. in the ratio of 2 : 3. This shows that the incidence of drug use among under-graduate girls and was very much higher compared to that in under-graduate boys.

Again out of 118 post-graduates there were 95 males and 23 females constituting 80.5 per cent and 19.5 per cent respectively i.e. they were in the ratio of 4 : 1 (approx.). The percentage of ever-users in males and females were 82.1 per cent and 91.3 per cent respectively. Here again the incidence of drug use among girls was higher compared to that of boys.

Thus, there is a significant difference in the educational level of drug use on the basis of sex. Higher proportion of girls at both the levels of education (under graduate and post-graduate) was using drugs compared to boys.

(b) Year-wise drug use

Of the 92 under-graduate current users, 43.5 per cent were first year students, 32.5 per cent were second year students, 17.4 per cent were third year students, 4.3 per cent were fourth year students and 2.2 per cent were fifth year students (third year, fourth year, and fifth year students included law students also). Of the 83 post-graduate current users, 45.8 per cent were previous year students and 38.5 per cent were final year ones. 15.7 per cent current users were M.Phil. and Ph.D. research scholars.

Since among the undergraduate students, only 22.9 per cent non-users and 7.5 per cent current users were studying in the first year, it could not be maintained that the 'new' entrants in college/university hostel life are more likely to be tempted to using drugs. Contrary to this, previous /first year of post-graduate and research students using drug current were 27.4 per cent (38 + 10), it could be said that the peak usage occurs so on after entering the college/university hostel life, or the 'new' students are more prone to drug use. This difference in the 'new entrants' users at the under-graduate and post-graduate levels is perhaps because the new under-graduates, after seeking admission, take sometime in developing contacts with others while new post-graduates are already matured students. (They had longer stay in the hostels. (See Table 4.11)).

TABLE 6.11YEAR-WISE DRUG USE (CURRENT)

S.No.	Class/ Year	No. of Students			Current- users	% of curr- ent users
		M	F	Total		
<hr/>						
1.	<u>UNDER-GRADUATE</u>					
a)	1st year	50	14	64	40	43.5
b)	2nd year	41	11	52	30	32.5
c)	3rd year	33	10	43	16	17.4
d)	4th year	15	2	17	4	4.3
e)	5th year	6	-	6	2	2.2
<hr/>						
	TOTAL	145	37	182	92	50.5 % of 92)
<hr/>						
2.	<u>POST-GRADUATE</u>					
a)	Previous	47	10	57	38	45.8
b)	Final	38	7	45	32	38.5
c)	Research (M.Phil Ph.D)	-	6	6	13	15.7
<hr/>						
	TOTAL	95	23	118	83	70.3 % of 83)

c) School type and drug use

Of the 149 male drug users (current), 63.5 per cent were who were educated in Convent, military and Central schools, 23.8 per cent in public/private schools and 12.7 per cent in Government/Municipal schools. Against this, of the 49 female drug users (current), 48.9 per cent were educated in Convent/Central Schools, 30.6 per cent in public/private schools, 20.5 per cent in Government/Municipal schools.

Among the non-users and past-users together, 38.6 per cent males and 36.4 per cent females were educated in Convent/Central/Military schools (See Table 4.12).

TABLE 4.12ASSOCIATION BETWEEN SCHOOL BACKGROUND AND SEXWISE DRUG-USE

TYPE OF SCHOOL	NON-USERS		PAST-USERS		CURRENT USERS		TOTAL	
	M	F	M	F	M	F	M	F
1. CONVENT/MILITARY/CENTRAL	20 (25.9)	3 (22.2)	22 (59.5)	12 (100.0)	80 (63.5)	24 (48.9)	122 (50.8)	28 (46.7)
2. PRIVATE/PUBLIC	14 (18.2)	2 (22.2)	10 (27.0)	-	30 (23.8)	15 (30.6)	54 (22.5)	17 (28.3)
3. GOVT./	43 (55.9)	5 (55.6)	5 (13.5)	-	16 (12.7)	10 (20.8)	64 (26.7)	15 (2.5)
TOTAL	77	10	37	2	126	49	240	60

The relationship between drug use and school background shows that education in Convent/Military/Central school does increase the use of drugs among students. The ever-users (past and current users together) totalled 128 out of 150 students, of these "elite" schools. Thus 85.3 per cent of such students were found using drugs, while out of 150 students who were educated in Government/Municipal/Private/Public schools (Ordinary Schools) only 86 (57.3 per cent) used drugs.

This relationship can be tested statistically on the basis of the figures arranged in Table 4.13.

TABLE 4.13

ASSOCIATION BETWEEN SCHOOL BACKGROUND AND DRUG USE

	Convent/ Military/ Central	Govt./Muni- cipal/Public/ private	Total
Non-user	22 (14.7)	64 (42.7)	86 (28.7)
Ever-user	128 (85.3)	86 (57.3)	214 (71.3)
TOTAL	N = 150 100.0)	N = 150 (100.0)	N = 300 (100.0)

Obtained x^2 = 28.74 ; Table x^2 = 3.841
 df = 1 ; p = 0.05

Since the calculated x^2 is greater than table x^2 , the null hypothesis that type type of school (background) does not effect the use of drugs is not justified. The fact emerges that more students educated in non-elite schools use drugs compared to those who were studying in elite schools (English medium, public convent schools).

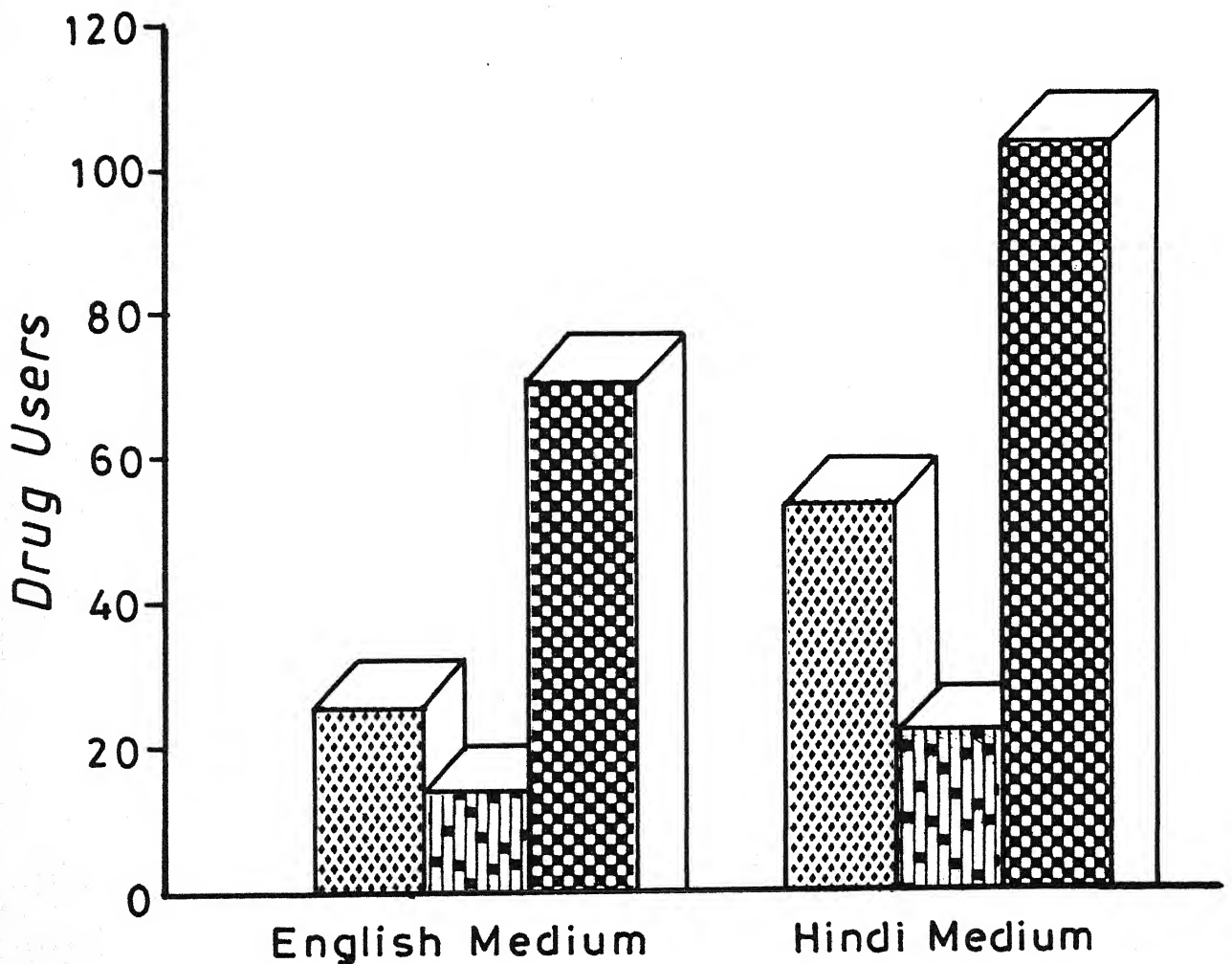
a) Instruction medium-wise drug use

Out of 214 students who used drugs (past and current drug users together) 84 (93.3 per cent) had English as their medium of instruction in the last three years of their school career against 130 students (60.7 per cent) who had Hindi and other similar languages, other than English as their medium of instruction.

Comparing males and females in these two categories of instructional backgrounds, 21.9 per cent girls with English medium were found drug-users as against 43.7 per cent male drug users. That is, male drug users were double of the female users. Non-English medium of instruction category had 79.1 per cent of girls and 56.3 per cent of boys as drug users (past and current together).

Relationship between Medium of Introduction & Drug Users

Non Users Past Users Current Users



The figures in table 4.14 show that **drug use varies with the medium of instruction**. Contrary to the popular belief that more English-educated youth take drugs compared to non-English educated youth, our findings indicate that drug use is more prevalent among non-English educated youth.

TABLE 4.14

RELATIONSHIP BETWEEN MEDIUM OF
INSTRUCTION AND DRUG USE IN THE SAMPLE

MEDIUM OF INSTRUCTION	NON-USERS	PAST-USERS	CURRENT USERS	PAST + CURRENT USERS	TOTAL (COL. 2 + 5)
1. ENGLISH	30 (34.9)	14 (35.9)	70 (40.0)	84 (39.3)	114 (38.0)
2. OTHER THAN ENGLISH	56 (65.1)	25 (64.1)	105 (60.0)	130 (60.7)	186 (62.0)
TOTAL	N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 214 (100.0)	N = 300 (100.0)

The figures in the above table show that out of 86 non-users 65.1 per cent were those who had non-English languages (mainly Hindi) as their medium of instruction and 34.9 per cent were English educated students. For the past and

current drug users together, the proportion of non-English educated and that of English educated students were 60.7 and 39.3 per cent respectively.

In the sample of 300 students, 28. per cent who had English as their medium of instructions in their school career used drugs either in the past or currently, while non-English instructional medium drug users were 43.3 per cent of the sample. And out of 186 non-English medium students about 70 per cent used drugs (in the past and currently), while out of 114 English medium students 75.4 per cent used drugs. These figures again show that the difference in medium of instruction does not affect use of drugs among students in any significant manner.

TABLE 4.15

CORRELATION BETWEEN MEDIUM OF INSTRUCTION AND DRUG USE

Medium	Non-user	Ever-user	Total
Hinai	56	130	186
English	30	84	114
TOTAL	86	214	300

$$\begin{array}{llll} \text{Obtained } x^2 & = & 0.495 & ; \quad \text{Table } x^2 & = & 3.841 \\ \text{df} & = & 1 & ; \quad p & = & 0.05 \end{array}$$

Since calculated value of x^2 is less than the table value of x^2 , it is proved that the null hypothesis that the medium of instruction is positively correlated with drug use is not justified. That is, even the schooling in Municipal/Govt. and non-elite schools, is unable to ustract the attention of the young hostelers away from the drug use culture.

e) Faculty-wise drug use

Patterns of drug use however, were quite different in each faculty. For example, the highest use of drugs was found among Law students followed by Engineering, Social Sciences, Arts, Medical and Science students. It indicated that inspite of the knowledte of and accessibility to drugs, the prevalence rate of drug use among Medical students is not high. Our study also supports the findings of 1976 and 1986 surveys (conducted by R-Ahuja) in Jaipur city that the highest incidence of drug use was found among Law students (1976 survey).

TABLE 4.16FACULTY BACKGROUND OF USERS AND NON-USERS

S.No.	Faculty	Non- users	Past- users	Current users	Total
1.	Science	23 (26.7)	8 (20.5)	13 (7.4)	44 (14.7)
2.	Social Science	6 (7.0)	5 (12.8)	10 (5.7)	21 (7.0)
3.	Arts	5 (5.8)	4 (10.3)	6 (3.4)	15 (5.0)
4.	Commerce	9 (10.5)	6 (15.4)	15 (8.6)	30 (10.0)
5.	Law	1 (1.2)	-	4 (2.5)	5 (1.7)
6.	Medicine	13 (15.2)	7 (18.0)	15 (8.6)	35 (11.7)
7.	Engineering	29 (33.70	9 (23.0)	117 (64.0)	150 (50.0)
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 9100.0)	N = 300 (100.0)

Does any association exist between drug use and professional and non-professional course background of the students ? Let us statistically test the null hypothesis that drug use is not related to professional (Engineering and Medical) and non-professional (Arts, Science, Social

Sciences, Law and Commerce). It may be reminded here that we did not include in our sample students of Management, Library Science and Polytechnics in the broad category of professional courses of study.

TABLE 4.17

CORRELATION BETWEEN DRUG USE
AND PROFESSIONAL AND NON-PROFESSIONAL COURSES

Course of study	Non-users	Ever-users	Total
1. Professional	42 (43.8)	143 (66.8)	185
2. Non-professional	44 (51.2)	71 (33.2)	115
TOTAL	N = 86 (100.0)	N = 214 (100.0)	N = 300 (100.0)

The difference in obtained and table values of x^2 shows that our hypothesis is valid. In other words, consumption of drugs varies with the professional and non-professional courses of hostelers. It has already been found that there is higher incidence of drug use among professional students (77.2 per cent) compared to non-professional students (61.7 per cent).

f) Academic Interest-wise Drug Use

In terms of academic achievement, 8.9 per cent drug users (current) were distinction holders, 31.4 per cent were first divisioners, 49.2 per cent were second divisioners, 8.5 per cent third divisioners and no failures in the last examination.

Since only 8.5 per cent current users were third divisioners or failures, it could be said that academic frustration is not the cause of drug use. Statistically also, the figures in Table 4.18 show that there is no relationship between drug use and academic performance (in terms of division obtained in examination).

TABLE 4.18

DIVISION OBTAINED IN LAST EXAMINATION
BY DRUG USERS AND NON-USERS

Division obtained	Non- users	Past- users	Current users	Total
1. Distinction	8.3	9.6	8.9	8.9
2. First	31.3	32.4	33.4	32.2
3. Second	50.5	48.6	49.2	49.3
4. Third	9.6	9.4	8.5	9.2
5. Failed	0.3	-	-	0.4

TOTAL N = 86 N = 39 N = 175 N = 300
 (10.0) (100.0) (100.0) (100.0)

Statistically also, the figures in table show that there is no relationship between drug use and division obtained in examination.

Obtained x^2 = ; Table x^2 =
 df = ; p =

TABLE 4.19

ASSOCIATION BETWEEN ACADEMIC BACKGROUND AND DRUG USE

Division obtained	Non- users	Ever- users	Total
Distinction/First	8	20	28
Second	30	71	101
Third	42	105	147
Failure	6	18	24
TOTAL	86	214	300

Since only about one-twelfth of current users (15) were third divisioners, it could be said that academic frustration is not the cause of drug use (See table 4.18).

Here obtained

x^2 (chi) = .26 ; Table x^2 = 7.815

df = 3 ; p = 0.05

x^2 Table value

Null hypothesis

Since obtained χ^2 is less than table χ^2 , it could be said that our null hypothesis that low academic achievement, such as, pass in third division or failure in the exams provides better inducement to drug use is rejected.

It may be pointed out that a high division in examination does not decrease drug use among students nor does a low division increase it.

g) **Curricular Activities and Drug-Use.**

To a question if they participated in various extra curricular/co-curricular activities, the responses from our respondents were very interesting. Out of 300 sampled respondents, 79.3 per cent replied that they participated in various such activities, 20 per cent participated in the National Cadet Corpse, 36.7 per cent in the National Social Service and 21.7 per cent in Games and Sports.

Similarly, participation of our respondents in various co-curricular activities was also very high. Their participation in leisure-time activities also shed important light on their varied interests, aptitudes and preferences.

Let us first analyse the association of drug use with extra-curricular activities. The figures in Table 4.20 show that there seems no participation or definite correlation between use or non-use of drugs and extra-curricular activities.

TABLE 4. 20

**PARTICIPATION* OF DRUG USERS AND
NON USERS IN EXTRA-CURRICULAR ACTIVITIES**

S.No.	Activity	Non- users	Past- users	Current users	Total
1.	N.C.C.	20.0	20.5	19.7	20.0
2.	N.S.S.	55.0	54.0	54.5	54.5
3.	Sports & Games	11.3	12.0	11.8	11.7
4.	Others	90.0	87.9	88.2	88.7
5.	All Activities	43.8	44.5	46.7	45.0
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)

* The total is more than 100 per cent in each category because of respondents' multi-activity participation.

TABLE 4.21PARTICIPATION* OF DRUG USERS AND
NON-USERS IN CO-CURRICULAR ACTIVITIES

S.No.	Activities	Non- users	Past- users	Current users	Total
1.	Classroom discussions	23.0	23.8	24.0	23.6
2.	Seminars	31.0	32.5	29.8	31.1
3.	Debates	33.8	34.2	35.6	34.5
4.	Eassy Compe- tition.	38.4	38.0	39.4	38.6
5.	General know- ledge competition	30.1	30.0	32.8	31.0
6.	Educational examinations	11.0	10.0	12.0	11.3
7.	Culture acti- vities	18.8	17.0	20.2	18.7
8.	All Activities	30.0	29.0	32.1	30.4
TOTAL		N = 86 (100.0)	N = 38 (100.0)	N = 175 (100.0)	N = 300 (100.0)

* The total is more than 100 per cent in each category because of respondents' multi-activity participation.

Taking now all the six variables pertaining to education of drug users together, namely, (i) course of study, (ii) medium of instructions in last three years of the school career, (iii) type of school, (iv) class of study, (v) division obtained and (vi) interest in extra-curricular/co-curricular activities and leisure time activities, it can be concluded that the first four variable are definitely related to drug usage but the last two have no significant relationship.

5. INCOME AND DRUG USE

A significant relationship was observed between economic status (of the families of drug users and non-users) and drug use. About two third of drug users (68 per cent) belonged to the families with annual income above Rs. 30,000, 25.6 per cent and 6.4 per cent belonged to middle and low income levels respectively. Affluent youth or students from the upper income groups (presumably getting a higher amount of pocket money from their parents) tend to experiment with drugs more than the students from the lower income groups (getting a smaller amount of money as pocket expenses).

TABLE 4.22

**LEISURE-TIME ACTIVITIES*
OF CURRENT DRUG USERS AND NON-USERS**

S.NO. LEISURE ACTIVITY	NON-USERS			CURRENT USERS		
	M	F	TOTAL	M	F	TOTAL
1. READING BOOKS	16 (20.0)	1 (16.7)	17 (19.8)	14 (11.1)	7 (14.3)	21 (12.0)
2. PLAYING CARDS	8 (10.0)	-	8 (9.3)	22 (17.5)	6 (12.2)	28 (16.0)
3. MOVIES	20 (25.0)	2 (33.3)	22 (25.6)	14 (11.1)	12 (24.4)	26 (15.0)
4. SOCIAL WORK	13 (16.2)	1 (16.4)	14 (16.3)	34 (27.0)	8 (16.3)	42 (24.2)
5. MUSIC/RADIO LISTENING	15 (18.8)	2 (33.3)	17 (19.8)	38 (30.1)	10 (20.4)	48 (27.4)
6. PAINTING/DRAWING	4 (5.0)	-	4 (4.7)	-	2 (4.1)	2 (1.17)
7. OTHERS	4 (5.0)	-	4 (4.7)	4 (3.2)	4 (8.2)	8 (4.6)
TOTAL	N = 80	N = 6	N = 86 (100.0)	N = 1226	N = 49	N = 175 (100.0)

All this shows that there is no relationship between drug use and lack of interest in extra-curricular activities.

TABLE 4.23RELATIONSHIP BETWEEN DRUG USERS AND
NON-USERS AND THE INCOME OF THEIR FAMILIES

Income	Non- users	Past- users	Current users	Past + Current users	Total
1. Below Rs. 18,000	21 (24.5)	2 (5.2)	13 (7.4)	15 (6.4)	36
2. Rs.18,000 to Rs. 30,000	23 (26.7)	10 (25.6)	50 (28.6)	60 (25.6)	83
3. Above Rs. 30,000	42 (48.80)	27 (69.20)	112 (64.0)	139 (68.0)	181
TOTAL. N= 86 N = 39 N = 175 N = 214 N = 300					
(100.0) (100.0) (100.0) (100.0) (100.0)					

Out of 175 current drug-using hostelers, 64 per cent belonged to the high income group families, 26.6 per cent and 7.4 per cent to middle and low income groups families respectively. Comparing past users with current users in the three income groups, it was observed that a slightly higher percentage of both low and middle income groups students was of current users than of past users, while past users in the high income group were slightly higher in percentage than the current users in that group.

Among non-users, 24.5 per cent belonged to low income group, 26.7 per cent and 48.8 per cent respectively to the middle and high income groups of non-users families.

TABLE 4.24

SOURCE OF GETTING MONEY

S.No.	Source	Non-users	Past users	Current-users	Total
1.	Parents	67.5	64.1	68.6	66.7
2.	Scholarship	17.6	10.3	14.2	12.0
3.	Part-time job	5.8	7.7	4.6	6.0
4.	Tuition	5.8	7.7	4.6	5.9
5.	Side business	4.7	7.7	3.4	5.4
6.	Others	2.3	2.5	3.4	2.7
7.	More than one source	2.32	-	1.2	1.3
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)

A significant relationship was observed between economic status (dependence on parents, partly dependent and partly independent and fully or almost independent) and drug use. About 66.4 per cent drug users, had no

independent source of income and were fully dependent on their parents and 72 (33.6 per cent) were supporting themselves partly or totally by scholarship, tuition, part-time job and business etc. (See Table 4.24).

An attempt was made to find out whether there was any correlation between drug use and economic dependence and independence of the users and non-users. It was found that a significant relationship existed between the two variables (See Table 4.25)

TABLE 4.25

CORRELATION BETWEEN DRUG USE AND ECONOMIC DEPENDENCE

Economic Independence/Dependence	Non-user	Ever-user	Total
1. Self-supporting	18	58	76
2. Others	68	156	224
TOTAL	86	214	300

Applying χ^2 that -

$$\begin{array}{llll} \text{Obtained value of } \chi^2 & = & 1.23 & \text{Table value } \chi^2 & = & 3.84 \\ & & \text{df} & = & 1 & & p & = & 0.05 \end{array}$$

We find that since obtained χ^2 value is lower than table χ^2 value, therefore our null hypothesis is not valid.

The null hypothesis was that use of drug is not related to economic dependence on others. The x^2 value indicated that null hypothesis is invalid. We, therefore, hold that economic independence does increase the drug use among students.

In our study, there was a direct question on the monthly income of the families of users and non-users. Information collected was tabulated in a foregoing table, (Table 4.23), which was used to show the relationship between the economic status of drug users' or non-users' families and drug use. We also asked them a question on amount of money spent every month on the leisure-time activities. The details of responses are given in Table 4.26.

TABLE 4.26

MONEY SPENT ON LEISURE-TIME ACTIVITIES

S.No.	Amount (in Rs.)	Non- users	Past- users	Current users	Total
1.	Less than 50	9.9	12.7	5.7	9.4
2.	50 to 100	46.3	45.7	47.8	46.6
3.	100 to 150	40.3	38.5	42.3	40.4
4.	150 to 200	2.3	1.7	2.7	2.2
5.	200 +	1.2	1.4	1.5	1.4
<hr/>					
TOTAL		N = 86	N = 39	N = 175	N = 300.
		(100.0)	(100.0)	(100.0)	(100.0)

The figures show that about 84-90 per cent of users and non-users spent between Rs. 50-150 on leisure time activities. Only 5.7 per cent of current users spent less than Rs. 50 compared to 12.7 per cent past users and 9.9 per cent non-users. Those of non-users, past users and current users, who spent Rs. 150 and above, were 3.5, 3.1. and 4.2 respectively. Only in respect of monthly expenditure between Rs. 50-100, Rs. 100-150 and Rs. 150 and above the current drug users spent a little more than the past-users and non-users. This very small difference in the expenditure pattern does not conclusively lead to the inference that drug users spend more on leisure-time activities (including buying drugs). This means that there is no relationship between drug use and amount of money spent on leisure activities. However, we can say that since more than two-third drug users spent between Rs. 50-150 on leisure time activities (including buying drugs), it shows that drugs taken by students are cheaper ones. This is supported by our frequency analysis of types and frequency of drugs used by our respondents. It indicated that a very large majority of them took alcohol and cigarettes and painkillers occasionally and only about 4.0 per cent were frequent users or habituals of narcotics and hallucinogens. This fact should serve as a dampness to the hoarse cries of the youth schulmbing to hard drug addict.

The figures pertaining to money spent on leisure-time activities can be rearranged for statistically testing the association between drug use and money spent on leisure time activities. Our null hypothesis is that increase or decrease in pocket money or amount of expenditure on leisure time activities does not affect those activities.

TABLE 4.27

CORRELATION BETWEEN MONTHLY
EXPENDITURE ON RECREATION AND DRUG-USE.

Monthly expenditure (in Rupees)	Non- users	Ever- users	Total
Less than 50.	9	20	29
50 - 100	40	101	141
100 - 150	35	86	121
150 +	2	7	9
TOTAL	86	214	300

On statistical analysis of the null hypothesis, we find -

Obtained value $x^2 = 0.269$; Table $x^2_{0.05} = 7.815$

df = 2 ; p = 0.05

Since obtained x^2 < Table x^2

Null hypothesis is disproved.

This means that drug use does not increase with the increase in money spent on leisure activities, or amount of pocket money does not affect the use of drugs.

6. RESIDENCE BACKGROUND AND DRUG USE

Taking past and current drug users together, 21.5 per cent had spent the first fifteen years of their life in villages, 64.5 per cent in small cities/towns and 14.0 per cent in large/metropolitan cities (See Table 4.29)

TABLE 4.28

RESIDENTIAL BACKGROUND OF FIRST FIFTEEN YEARS OF LIFE OF USERS AND NON-USERS

S.No.	Place of Residence	Non-users	Past-users	Current-users	Total
1.	Village	18 (20.9)	11 (28.2)	35 (20.0)	64 (21.3)
2.	Small city	53 (61.6)	18 (46.1)	120 (66.6)	191 (63.7)
3.	Large/Metropolitan city	15 (17.5)	10 (25.6)	20 (11.4)	45 (15.0)
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)

TABLE 4.29*RESIDENTIAL BACKGROUND OF DRUG USERS

S.No.	Residence	Past- users	Current users	Past + Current users	Total
1.	Village	11 (28.2)	35 (20.0)	46 (21.5)	64 (21.3)
2.	Small City	18 (46.1)	120 (66.6)	138 (64.5)	191 (63.7)
3.	Large/Metro- politan City	10 (25.6)	20 (11.4)	30 (14.0)	45 (15.0)
TOTAL		N = 39 (100.0)	N = 175 (100.0)	N = 214 (100.0)	N = 300 (100.0)

* Obtained x^2 = 8.460 ; Table x^2 = 12.591
 df = 2 ; p = 0.05

This means that since a preponderance and number of drug consumers were urban (including semi-urban and metropolitan) ; several drug users being comparatively for less. The null hypothesis is not dependent on urban/rural residence is found invalid (or unjustified).

If we calculate the percentage of non-users and users in the students with rural, semi-urban and urban backgrounds, we find that users with rural background

were 46 (71.9 per cent) compared with 18 (29.1 per cent) non-users, users among small city dwellers were 158 (72.2 per cent) compared with 53 (27.8 per cent) non-users and among large/metropolitan city dwellers the users were 30 (66.7 per cent) compared with 15 (33.3 per cent) non-users. These figures showed the following ratio between non-users and users with three separate residential backgrounds :

2 : 5	(rural)
1 : 3	(semi-urban)
1 : 2	(urban)

That is, association of drug use does vary with residential background. Speaking in simple terms, out of 7 rural residents 5 used drugs. Out of 4 semi-urban residents only one used drugs and out of 3 urban residents, 2 used drugs. The villagers were the largest drug users followed by urban and semi-urban residents. Surprisingly, equal number of rural and urban (semi-urban and urban) students were found using drugs. In this situation, the association of drug use with rural and urban residents does not vary so as to lead to any significant result. In other words, residence does not affect the incidence of drug use among hostelers.

Let us statistically examine the hypothesis pertaining to the relationship between residential background and the incidence of drug use.

TABLE 4.30

CORRELATION BETWEEN RESIDENCE BACKGROUND AND DRUG USE

	Residence	Non-users	Ever-users	Total
1.	Village	18	46	64
2.	Small City	53	138	191
3.	Large/Metro-politan City	15	30	45
	TOTAL	86	214	300

$$\text{Obtained } x^2 = 0.563 \quad ; \quad \text{Table } x^2 = 5.991$$

$$\text{df} = 2 \quad ; \quad p = 0.05$$

Since obtained x^2 table x^2 in the null hypothesis that there is no association between drug use and new and old city dwellers is supported by the application of x^2 test.

7. LENGTH OF STAY IN JAIPUR CITY OF DRUG USERS AND NON-USERS

Comparing the length of of stay in Jaipur City of the drug users with that of the non-users, 46.7 per cent users and 51.3 per cent non-users were found to be new to the city (having stayed in Jaipur for three years or less).

TABLE 4.31

LENGTH OF STAY IN JAIPUR CITY OF USERS AND NON-USERS

S.No.	Years	Non-users	Past-users	Current users	Total
1.	1 -	20 (23.3)	7 (17.9)	27 (15.4)	54 (18.0)
2.	1 - 3	25 (29.1)	10 (25.6)	56 (32.0)	91 (30.4)
3.	4 - 6	27 (31.4)	13 (33.3)	55 (31.4)	95 (31.7)
4.	7 - 9	8 (9.3)	6 (15.4)	25 (14.3)	39 (13.0)
5.	10 +	6 (6.9)	3 (7.7)	12 (6.9)	21 (7.0)
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)

Statistically speaking,
 obtained x^2 = 2.24 ; Table x^2 = 5.991
 df = 2 ; p = 0.05

Since calculated x^2 is smaller than table x^2 , null hypothesis that the increased in stay in the city affects incident of drug use among urbane hostelers is supported.

Since 34 out of 24 drug using students i.e. 15.9 per cent were quite "new" to the city, drug use cannot be attributed to culture shock "encountered by the "new comers" in the city. But we hold that the longer the stay of a student in the city, the greater is the tendency in him/her to use drugs. What are the reasons for this phenomenon ? Most probably, this is due to the impact on him/her of urbanism which is associated with modernism, movie culture, greater temptation to drug use and heightened tension of city life. Maybe, it is also in part due to the easy availability of recreational and other drugs. All this is taking place unabated despite the fact that the world organisation (UNO) and a host of anti-drug outfits as well as the Govt. of India have launched a concerted drive to fight drug menace. The use of drugs among the elites has acquired social respectability. The clandestine time trade in drugs especially, contra-band as narcotics has proliferated because of the implicit support of the mass-media and the insidious connivance of the corrupt beurocracy which is in league with drug maphias. The modern electronic media and other currents have glorified drug-culture and a sort of euphoria has resulted therefrom which is taking the anger generation under its corrupting influence.

Out of 300 (our sample) 82.2 per cent were Hindus (less SC/ST) and 17.8 per cent were other than Hindus, including Jains, Sikhs, Buddhists, SC/ST, Christians and Mislms.

Out of 86 non-users, the Hindus were 82.2 per cent and 17.8 per cent other than Hindus. Jains, Sikhs, Christians, Muslims, Buddhists and SC/ST were 6.1, 2.3, 1.0, 2.3, 0.2, and 5.9 per cent respectively. Out of 214 drug users (past and current together), among the 19.4 per cent non-Hindus (including SC/ST) 4.3. per cent were Jains, 2.6 per cent were Sikhs, 2.3 per cent Muslims, 1.7 per cent Christians and about 1 per cent Buddhists, SC/ST were 7.6 per cent.

We do not consider it meaningful to compare these percentages of drug users in our sample with the percentages of different religionists/followers of religions) in the entire population of Jaipur city according to 1991 census report. For the focus of our study is the student population residing in hostels attached to different colleges and Rajasthan University located in Jaipur city and not the general students population in the city.

TABLE 4.32ASSOCIATION BETWEEN LENGTH OF STAY
IN THE CITY AND DRUG USE

S.No.	Length of Residance	Non- users	Ever- users	Total
1.	1 Year	20	34	54
2.	1-3 years	25	66	91
3.	3 + years	41	114	155
TOTAL		86	214	300

8. RELIGION AND DRUG USE

Out of 214 drug users (past and current together), 80.5 per cent were Hindus (excluding SC/ST) and 19.4 per cent were other than Hindus.

TABLE 4.33RELIGION-WISE DRUG USE

Religion	Non- users	Past users	Current users	Total
1. Hindus (Less SC/ST)	82.2	81.0	80.2	82.2
2. Jains	6.1	4.2	4.3	6.8
3. Muslims	2.3	2.4	2.1	1.8
4. Christians	1.0	1.7	1.7	1.0
5. Sikhs	2.3	2.5	2.8	1.8
6. Buddhists	0.2	0.9	1.0	0.4
7. SC/ST	5.9	7.3	7.9	6.0

TOTAL

N = 86 N = 39 N = 175 N = 300
(100.0) (100.0) (100.0) (100.0)

9. LANGUAGE SPOKEN BY DRUG USERS AND NON-USERS

To our question what languages were spoken by respondents in our sample, we could not elicit sufficiently accurate information as to the different languages (Rajasthani, Hindi, Urdu, English, Punjabi etc.) spoken by drug users and non-users. We had to assume, therefore, that except English or other foreign languages spoken by foreign students in our sample (which was a very very small proportion, almost microscopic minority), the remaining respondents (both drug users and non-users) were found speaking generally Hindi. Hence, we did not deem it fruitful to find out association of languages with drug use or non-use.

10. SOURCE OF GETTING DRUGS

What are the sources from which drugs are usually obtained by students ? Our data showed that 47.2 per cent drug users obtained drugs from the market, 26.3 per cent from the doctors, 13.5 per cent from friends, 3.5 per cent from pedlers and 4.7 per cent from other sources while 4.8 per cent did not disclose the source. It is difficult to say whether the respondents, who did not identify the source of getting drugs, actually got them from the drug

pushers. The probability is that this cannot be the source because a majority of our non-respondents were using drugs which were obtained from the market, and not from the pedlers. We, therefore, maintain that :-

- (i) Channels for obtaining drugs are usually legitimate (87 per cent).
- (ii) drugs are generally obtained from non-medical sources (69 per cent),
- (iii) medical sources are used more by girls than boys ;
- (iv) the non-medical sources are generally friends ;
- (v) drugs obtained from the market (shop counters) are painkillers and tranquilisers ; and
- (vi) narcotics and hallucinogens are usually obtained from the pedlers, or under the counters (See Table 4.34).

TABLE 4.34SOURCE OF GETTING DRUGS BY CURRENT USERS

S.NO.	SUBSTANCE	MARKET	DOCTORS	FRIENDS	PEDLERS	OTHER SOURCES	SOURCES UNDIS- CLOSED	TOTAL
1.	ALCOHOL	48.3	-	44.3	-	2.7	4.7	100.0
2.	TOBACCO	68.4	-	31.6	-	-	-	100.0
3.	AMPHETAMINE	62.0	32.0	-	-	2.0	4.0	100.0
4.	BARBITURATES	62.1	36.2	1.7	-	-	-	100.0
5.	CANNABIS	59.3	-	40.7	-	-	-	100.0
6.	HEROIN	-	-	4.61	53.9	-	-	100.0
7.	PETH/MORPHINE	18.6	75.1	6.3	-	-	-	100.0
8.	OPIUM	37.2	50.6	8.9	3.3	-	-	100.0
9.	L.S.D.	-	-	100.0	-	-	-	100.0
10.	PAINKILLERS	53.4	43.2	3.4	-	-	-	100.0
11.	TRANQUILISERS	39.2	56.1	2.7	-	2.0	-	100.0
12.	ALL DRUGS	-						100.0

11. ALCOHOLISM

Alcohol and Tobacco are the most widely used drugs among hostelers. It would, therefore, be worthwhile to analyse the patterns of alcoholism and tobacco consumption (largely smoking and use of 'Gutakas') and problems caused by their use. A distinction must be made between "drinking liquor" and alcoholism". A large number of people including students, drink to the point of getting into difficulties, and very few develop serious alcohol related problems termed as 'alcoholism'². Therefore, the less serious problems such as entering into arguments (excitedly or angrily) or occasionally missing work or college (class) because of drinking have little significance in themselves. But these difficulties can also be a part of early development of the personality disorder. These lesser problems, therefore, must not be completely ignored.

One of the studies on the use of mind-altering drugs in the U.S.A. says that alcohol accounts for more drugs related problems, than all other psychoactive drugs combined : serious illness, traffic deaths and homicides

2. R. Ahuja, **Drug use - among College/University Students in Jaipur City** (1987 Survey Report) p. 59.

and other forms of crimes. The situation in India is not very different on this score. Besides creating "tolerance" in the user, the alcoholic also undergoes a withdrawal syndrome, one symptom of which is delirium tremens. Alcohol is also implicated in two important ways in other psychoactive drug use. First, it often serves as a "gateway" drug that leads to the use of other psychoactive substances ; persons begin to use alcohol long before they use other psychoactive drugs. Second, it is frequently used in conjunction with other drugs. Persons who drink wine, smoke cigarettes and also smoke hashish marijuana) simultaneously are referred to as multiple drug users. Use of alcohol with drugs can sometimes lead to serious physical repercussions.³ For this purpose, it was thought necessary by us to study the type (soft and hard liquor and Indian made and foreign liquor), the quantity (pint or bottle per day/week/month) and the frequency of consuming alcoholic beverages by the hostelers.

The diagnostic criteria have been laid down by and for the researchers on studies on alcoholism.⁴ It has been

3. R.C. Stephens, **Mini-Altering Drugs**, Sage Publications, New Delhi, 1987, p. 28.

Also refer to Dr. Bhim Sain's study **Alcohol Addiction**. H.K. Publishers & Distributors, New Delhi, 1989, which throws more light on the most dilemmatic drink, its nature and dimensions and prohibition.

4. Schuchit, **Drug and Alcohol Abuse**, p. 45.

noted that both "alcohol abuse" and "alcohol dependence" encompass both a pattern of "pathological alcohol use" (e.g. need for daily use, repeated efforts to control, alcoholic black-outs and continuation of drinking despite the problems **and** impairment in social or occupational functioning due to alcohol (e.g. alcohol related violence, absence from College/work, arguments with significant others, etc.)⁵. For purposes of utility of our research, we followed Ram Ahuja and adopted the diagnostic criteria in relatively objective terms. We avoided such evaluative statements as "I drink too much" or "I feel that I am becoming too psychologically dependent on alcohol."

The criteria stated by Dr. Ahuja were :

- 1) the quantity frequency-variability ;
- 2) psychological dependence in terms of subjective experience (depression, hallucinations, disorganised thinking, loss of interest in usual activities, etc.). (It is very difficult to quantify this objectivity) ;
- 3) body effects (e.g. insomnia, lethargy, constipation, etc.) ;

5. Schuchit, op. cit. p. 45.

- 4) socio-economic problems related to alcohol (e.g. marital problems, absenteeism, accidents, etc.) ;
and
- 5) withdrawal or abstinence syndrome when the respondent stops taking alcohol.

We found that among 35 'infrequent' drinkers (who took alcohol less often than a month or once a month), 42.8 per cent took one pint over a period of one month, 22.9 per cent one bottle, 14.3 per cent two bottles, 14.3 per cent three to four bottles and 5.7 per cent five or more bottles.

Among 18 "frequent" (28.1 per cent) alcohol drinkers (who took alcohol once a week or several times a week), 44.4 per cent took one pint over a period of one week, 22.2 per cent one bottle and 16.7 per cent two bottles, 11.1 per cent three to four bottles and 5.6 per cent five or more bottles. It should be made clear here that the respondents who confessed drinking alcohol 3 or more bottles per week usually shared drinks with their friends.

Among 11 "habitual" drinkers, 5 (45.5 per cent) were almost addicts. Both "habituals" and addicts took one

or more than bottles per week. 6 habituals (54.5 per cent took one to two bottles per week, while 5 habituals (45.5 per cent) took 4 or more bottles per week.

TABLE 4.35

QUANTITY OF LIQUOR TAKEN BY LIQUOR USERS

S.No.	Quantity	Over a period of one month	Over a period of one week	In a day
1.	Upto one pint	6.1	6.3	5.3
2.	Upto one bottle	4.2	3.7	3.6
3.	Upto two bottles	3.2	3.1	3.2
4.	Upto three bottles	3.0	2.8	3.0
5.	Upto four bottles	2.8	2.6	2.8
6.	Upto five bottles	2.0	1.5	2.6
7.	Upto six or more bottles	1.6	1.0	1.0
8.	Can't specify	-	-	-
9.	Nil	77.1	78.7	78.5
TOTAL		N = 64	N = 64	N = 64

Since 35 out of 64 current alcohol drinkers (54.7 per cent) were "infrequent" users and since the intake of 44.4 per cent frequent and daily users was upto one point only in a week, and since students drinking daily constituted 3.7 per cent of total hostelers studied, the picture of taking school is not at all alarming. "It also points out how onwise it might be to equate drinking" and "alcoholism" and demonstrates the need to view figures on alcoholism from a longitudinal perspective, "to quote Dr. Ahula.⁶

TABLE 4.36

ALCOHOL DRINKING BY STUDENTS IN THE SAMPLE

1.	Percentage of alcohol drinkers	21.3
2.	Frequency of average drinker	
	a) Infrequent	54.7
	b) Frequent	28.1
	c) Habitual	17.2
3.	Quantity of average drinker per month	
	a) One pint	54.7
	b) One bottle	28.1
	c) Two to four bottles	9.4
	d) Five or more bottles	7.8
4.	Percentage of hopelessly lost to drinking (hard alcoholic)	-

The foregoing analysis leads to the conclusion that drinking among our respondents (hostelers) is not a hopeless disorder. As a recreational drug alcohol has overtaken all other drugs (excluding tobacco which is the second most widely used substance by hostellers). It does enjoy overwhelming pre-eminence among the youth, but excepting chronic drinking in an extremely slender population, the most widely prevalent drinking is just infrequent/occasional. We observed that 80 to 90 per cent of drinkers had the will and capability to abstain or seriously limit their drinking without any exposure to formal treatment but with proper guidance.⁷ One can reasonably expect control over alcohol drinking by the youth. But serious doubts relate to when, how and who will undertake this responsibility.

12. TOBACCO

Nicotine, in its various forms, is one of the most widely used stimulant, despite its well known documented contributions to the national morbidity and mortality rates. The death rate for people who smoke two or more packages of cigarettes etc. a day is twice as high as that

7. R. Ahuja, Drug use Among College, University Students in Jaipur City (1987 Survey Report, Unpublished), p. 62.

of people who do not smoke. Chronic smokers have risks of death from lung cancer, fatal heart attack and chronic obstructive lung disease. They are also health hazards to all those who live, stay or work in proximity with them (technically called passive smokers). In India, tobacco alone is responsible for 6 lacs annual deaths. Even smoking the tobacco cigarettes (or bidi etc.) has become these days a controversial issue that has philosophical or moral overtones. One may choose to smoke, but does one have the right to alter the air that others must breathe.

The physiological consequences of smoking, the psychological and social forces for and against smoking and the individual rights versus public safety controversy are issues, that make the study of smoking and smoking behaviour specially intriguing.⁸

In the present study, 30 per cent of the total hostelers (sampled 300) were found using tobacco with or without alcohol or tobacco and alcohol plus drugs. The current users of drugs in our sample constituted 58.3 per cent. Of the 175 current users 51.4 per cent used only tobacco or alcohol or both, while 49.6 per cent used other drugs with or without tobacco and/or alcohol. (See Table 3.1 of Chapter 3).

1. D.E. Dusek & D.A. Girdano, **Drugs**, Asian Books Pvt. Ltd., New Delhi, 1987, p. 142.

As regards the quantity of cigarettes (bidis, etc. taken by our respondents, it was found that most of the current smokers (or eaters of 'gutaka', tobacco in betels etc.) i.e. 40.0 per cent used less than a dozen cigarettes in a day, 4.0 per cent used between a dozen and two dozen (more than one to two packs) and only 2.0 per cent were found using more than two packs per day. Beside cigarettes and bidis, "gutaka" and "zarda" were very popular among hostelers, compared to 27 per cent of boys used to smoking, only 13.3 per cent girls were actually smoking and that too largely occasionally but in lesser cases habitually. Out of 60 girls in the sample only 2 were found smoking habitually. Most of the girl drug users (86.7 per cent) used tobacco in its "gutaka" or "zarda" form. Thus, only 2 to 3 per cent of both sexes of hostelers were found chronic tobacco users. "Habituals" among boys were 13.2 per cent (current users), while among girls this percentage fell to 4 per cent. These findings suggest that tobacco use among the hostelers still today prevails in the form of a stimulant. The users do not consider tobacco as a drug. It's wider social acceptability is clearly reflected in their behaviour. They refrain from smoking specially on occasions when they are "obliged" to show respect or deference to their elders, teachers and other dignitaries.

TABLE 4.37QUANTITY OF TOBACCO USED BY HOSTELERS

S.No.	Quantity per day	Current users	Past users	Past + Current users
1.	<u>CIGARETTES ETC.</u>			
i)	Less than 12	40.0	36.6	39.7
ii)	12 to 24	4.4	6.6	5.0
iii)	24 +	2.2	3.3	2.5
2.	<u>GUTAKA</u> (1 to 2)	47.7	50.0	50.0
3.	<u>ZARDA</u> (4 to 8 times)	5.5	3.5	3.3
<hr/>				
TOTAL		N 90 (100.0)	N = 30 (100.0)	N = 120 (100.0)

If we take past and current tobacco users together and calculate their proportion in the sample (300), the results are more interesting. Out of 40 per cent tobacco users, 15.6 per cent smoke less than 12 cigarettes in a day, 20 per cent use one to two small pouches of 'gutaka', 2 per cent smoke 12 to 24 cigarettes in a day and barely one per cent are 'hard smokers' (smoke above 24 cigarettes) and only 13 per cent eat 'zarda', 4 to 8 times a day in betels or singly.

TABLE 4.38QUANTITY OF TOBACCO CONSUMED BY PAST
AND CURRENT USERS IN THE SAMPLE

S.No.	Quantity per day	Current- users	Past- users	Past + Current users % of sample
1.	<u>CIGARETTES ETC</u>			
i)	less than 12	36	11	15.6
ii)	12 to 24	4	2	2.0
iii)	24 +	2	1	1.0
2.	<u>GUTAKA</u> (1 to 2)	45	15	20.0
3.	<u>ZARDA</u> 94 to 8 times)	3	1	1.3
		N = 90	N = 30	N = 300

Thus, 'habituals' of cigarettes and 'zarda' were 2.0 and 1.3 per cent respectively, and hard smokers were meagre 1.0 per cent of the sampled students. Again, these figures suggest that the queen nicotine has not yet cast its horrible dragnet around hostel residents in Jaipur city.

A SYNOPTIC VIEW OF THE FINDINGS

Let us now have a synoptic view of the relationship between demographic cum social-economic variables and drug use among over respondents. Taking all the variables pertaining to social characteristics of the drug users together, it appears that hostellers in certain socio-economic categories run a relatively greater risk of encountering and using drugs. Our study points out a significant correlation of drug experience with **five factors :**

- i) higher income of the user's family.
- ii) adolescent and post-adolescent age groups. (very young and post very young age groups) ;
- iii) education in English medium convent and public central and military) schools ;
- iv) class of study and course of study - undergraduate and post-graduate/professional and non-professional.
- v) marital status.

From the group with no drug experience (non-users) to that with low experience (past users) or high experience (current users) or intensive experience (addicts or drug dependents) there is a steady shift up the economic scale, as well as high average age. The present study does indicate significant relationship between drug usage and class of study (under-graduation Versus Post-graduation), as well as course of study (Professional Versus non-Professional). No relationship was indicated between drug usage and academic achievement (division obtained) and interest in co-curricular and extra-curricular activities.

Drug use/abuse thus, is not distributed among College/University hostellers in a random fashion. Its prevalence is very low where there is economic scarcity and dependence, predominance of traditional values and rigid control in the families of hostellers carries its influence in the hostel life too. This discourages use of drugs among hostel inmates while 'open' or 'liberal' atmosphere of inmates' families encourages drug use. Against this, high income groups, adolescent and post-adolescent age group (16-21 years) students, who had their middle and secondary education in elite schools and

hostel-attached institutions, economically more self-supporting students and those pursuing under-graduate and professional courses could be indentified as 'high risk' categories in drug usage. In these categories 'large number', not 'all', are exposed to drug experience.

The characteristics of these 'potential' students vis-a-vis the role of family and the peer group in their life (career) and the factors motivating and conditioning drug use will be analysed in the next chapter.

*

CHAPTER - V

MOTIVATIONS FOR DRUG USE

inking and Smoking in friend's Company



CHAPTER - V

MOTIVATIONS FOR DRUG USE

In this chapter, our interest is focussed on the causes of drug abuse. Why does one use drugs ? How does one come to depend on drugs ? What attempts has he/she made to withdraw from drugs ?

1. INITIATION INTO DRUG USAGE

Let us start with when the drugs (including alcohol and tobacco) were first used by the students.

Of the 214 drug users in our sample, about one-ninth (23 or 10.7 per cent) had taken drugs for the first time in their middle school years, about one sixth (34 or 16.4 per cent) during secondary and senior secondary school i.e. 9th to 12th classes. Comparing the past users with the current users, it was found that the number of past-users, who took drugs first in college life, was 21 (53.9 per cent) which was about one-sixth of those who took drugs after entering college (135 of 77.1 per cent) while the number of past users who took drugs first during secondary and senior secondary years was about less than half of the number of current users who took drugs first in this period (10 or 25.6 per cent in

comparison to 25 or 14.3 per cent). This shows that a small number of the current users had started taking drugs in school years and continued to use them in college/university life. In other words, for those who took drugs only to taste them or to have some experience of them, college life was very crucial. (See Table 5.1).

TABLE 5.1

WHEN DRUGS WERE FIRST TAKEN BY PAST AND CURRENT USERS

When first used	Past users	Current users	Ever-users
1. Middle school years	8 (20.5)	15 (8.6)	23 (10.7)
2. Secondary/ Senior secondary years	10 (25.6)	25 (14.3)	35 (16.4)
3. College/ University	21 (53.9)	135 (77.1)	156 (72.9)
TOTAL	39 (100.0)	175 (100.0)	214 (100.0)

If we calculate past and current users out of ever-users, we find that out of 214 ever-users 8 and 15 past and current users respectively had started taking drugs in their middle school years, 10 and 25 in their

secondary/senior secondary school years and during college/university life, only 21 past users (9.8 per cent) compared to 135 current users (63.1 per cent) compared to 135 current users (63.1 per cent) had started taking drugs for the first time. This analysis also supported the fact that college/university life is very crucial for experimentation with drugs.

TABLE 5.2

WHEN DRUGS WERE FIRST TAKEN
SEX-WISE BY PAST AND CURRENT USERS

WHEN USED FIRST	PAST USERS		CURRENT USERS		EVER USERS	
	M	F	M	F	M	F
1. MIDDLE SCHOOL YEARS	7 (20.6)	1 (20.0)	9 (7.1)	6 (12.2)	16 (10.0)	7 (13.0)
2. SECONDARY/SENIOR SECONDARY SCHOOL YEARS	9 (26.5)	1 (20.0)	14 (11.1)	11 (22.4)	23 (14.4)	12 (22.2)
3. COLLEGE/UNIVERSITY LIFE	18 (52.9)	3 (60.0)	103 (81.7)	32 (65.4)	121 975.6)	35 (64.8)
TOTAL	34 (100.0)	5 (100.0)	126 (100.0)	49 (100.0)	160 (100.0)	54 (100.0)

If we take male and female drug users separately, 24.4 per cent males (39 out of 160) first took drugs before entering college (10.0 per cent during middle school and 14.4, per cent during secondary/senior

secondary school years) as compared with 35.2 per cent (19 out of 54) females (13.0 per cent in middle school and 22.2 per cent in secondary/senior secondary). Against this, 75.6 per cent males and 64.8 per cent females first experimented with drugs after entering college. It could, therefore, be maintained that to prevent them from developing the drug habits, girls entering college need more control than boys, while boys need more control right from the senior secondary school years.

Of the 156 drug users (121 males and 35 females) in the sample who started using drugs only in college years, 26.9 per cent started taking them in the first year of college life, 26.2 per cent in the second year, 12.8 per cent in the third year, 16 per cent in the fourth year and 18.1 per cent in the fifth year. This points out that the first two years of college life are more crucial in the career of students in indulging in deviant drug behaviour.

Of the 121 male drug users who first experimented with drugs in college life, 64 (52.9 per cent) took them in first and second years, while of the 35 females in this

group, 19 (54.2 per cent) used them in these two years. In the last two years of college life, the percentages of males and females were 26.9 per cent and 31.4 per cent respectively. It is thus clear, that the first two years of college life are equally crucial both for boys and girls. The post-graduate period (fourth and fifth years) in the college life of both girls and boys is less crucial compared to under-graduate period for indulging in deviant drug behaviour.

2. SOURCE OF FIRST SUGGESTION

When 214 drug users in the sample were asked who suggested first the use of drugs to them, 77 (36 per cent) informed that they had taken drug for the first time, without it being suggested by any person, i.e. they had taken drug on self-suggestion, 80 (37.4 per cent) had taken on the suggestion of friends (in 28 per cent cases by hostel friends and in 9.4 per cent cases by outside hostel friends), 11 (5.11 per cent) on the suggestion of some member of the family (in 4.2 per cent cases by parents and in 0.9 per cent cases by brothers or sisters), 19 (8.9 per cent) on the suggestion of physicians and 27 (12.6 per cent) on the suggestion received through mass media (See Table 5.3).

TABLE 5.3FIRST SUGGESTION FOR DRUG USE

Who prompted	Past users	Current users	Ever users
1. Self curiosity	14 (35.9)	63 (36.0)	77 (36.0)
2. Physician	3 (7.7)	16 (9.1)	19 (8.9)
3. Parents	1 (2.6)	8 (4.6)	9 (4.2)
4. Sublings & relatives	-	2 (1.1)	2 (0.9)
5. Friends	16 (41.0)	64 (36.6)	80 (37.4)
6. Mass Media	5 (12.8)	22 (12.6)	27 (12.7)
TOTAL	39 (100.0)	175 (100.0)	214 (100.0)

61.7 per cent in the sample revealed that they already had knowledge before taking them while 38.3 per cent denied having had any such knowledge.

Using these figures as the basis, let us statistically test the hypothesis regarding the relationship between prior awareness of drugs and the incidence of drug usage.

TABLE 5.4RELATION BETWEEN PRIOR KNOWLEDGE OF DRUGS
AND DRUG USAGE BY EVER-USERS IN THE SAMPLE

Prior knowledge	EVER-USERS		Total
	Male	Female	
Yes	102	30	132
No	58	24	82
TOTAL	160	54	214

Taking the source of first suggestion in the sample, we find the significant role of friends (37.4 per cent) in initiating the respondents to the drug usage. It is equally significant to note that about the same percentage of hostel inmates had taken the drug first on their own initiative to experience it out of curiosity.

We have followed Dr. A.R. Ahuja in delineating the drug users on the basis of "initiative factor". He has classified them into three sub-groups :

(1) Self-Directive, (2) Submissive and (3) Adaptive.¹

1. R. Ahuja, *Sociology of Youth Sub-Culture*, p. 56.

Self-Directove are those who are initiated into drug use on their own volition. They include students who are ambitious and introspective. Some of them are openly hostile to society's code of conduct prescribed or suggested for the youth. They have a feeling that the elders have no right to preach morals to them or to lay greater emphasis on their obstinence from drugs when they (elders) themselves in large numbers are drug indulgents. A few youths have premissive family training too. We don't subscribe to the view that self-initiators take to drugs because they have a feeling of insecurity. Submissive are those who are initiated into drug use by friends. They can be described as students who are timid and unaggressive and believe in avoiding conflicts. Some of them have inconsistent family training. Adaptive are those who are initiated into drug use by medical advice given either by physicians or family members or mass media. Family members and mass media sometimes also lure the youth into drug use by surreptitious or indirect advice which in no way is medical. These students are self-assured and have no signs of anxiety.

Of the total drug users in the sample, 36 per cent belong to the first group, 37.4 per cent to the second group and 26.6 per cent to the third group.

In our study, though mass media was found to have its impact on only 12.6 per cent of the respondents, yet we are skeptical about the effect of this factor. Dr. Ahuja in his study aforementioned has argued that the effect of mass media is not so significant. "The assumption that individuals can be manipulated merely by subjecting them to the mass media is overly simple and misleading. It is increasingly obvious that the knowledge of interpersonal environment of the individual is basic to an understanding of what exposure to mass media advertising means to him and of what his response to that exposure is likely to be."²

However, the effect of mass media should not be totally discounted. At the very minimum the advertisement of various drugs (or manifestation of drug usage by characters in print media or on the silver-screen) suggests the uses and effects of those drugs. Through intensive interviews of our drug-using respondents we could confirm our hypothesis that youth are motivated to drug use, to a great extent, by their reference groups. Such groups are usually their friends, fiction characters, intellectuals and high placed executives/professionals whom they think or imagine as their ideals. In the light

2. Ibid. p. 57

of these observations, the impact of mass media of communication on what a young college/university student thinks about and does with drugs, including alcohol and cigarettes, needs critical review.

It is true that like age peer-groups, mass media have the characteristics of exposing the young people, particularly studying in colleges/universities, to alternative models of behaviour which do not necessarily support the peer model or the parental model. In a complex society, this problem of confronting a young audit with alternative and sometimes, contradictory models of behaviour is, of course, not confined to the use of drugs alone. Books, magazines, newspapers, theatrical performances, movies, radio and television continually suggest alternatives in politics, economy, social organisation, food and dress, amusements and recreation, ethics and styles of life in general to the young without necessarily being mediated through parents, friends or other adults. Many a time it is opined that mass media, particularly advertising, are responsible for the prevalence and incidence of drug usage.³ Such an assumption is, however, untenable. To be sure, our present

3. A.G. Noorani, *Mass Media and the Modern Life*. Times of India, 23 September, 1990.

study is not a carefully controlled study demonstrating a precise relationship between the prevalence of drug advertising and the incidence of drug use. Yet we cannot accept a close relationship between the two on inferential grounds. If the non-user could be encouraged (or incited) merely by exposure to sophisticated advertising, the existence of a large segment of non-users among our students and other youths in our society, who presumably are also exposed to such advertising, would be difficult to explain.

Advertising, through mass media, of various drugs merely suggests the uses and effects of those drugs. Such a suggestion would tend to confirm the impressions of the young individual whose interpersonal relationships have oriented him to drug use. It remains to be demonstrated, as pointed out by Dr. Ahuja and others, that the advertisements are crucial in transforming into a drug user the obstinent young student whose interpersonal relationships support his abstinence.⁴ However, one must pause here to ponder over the effects of advertising of alcohol : (beer, whisky, wine etc.), cigarettes and certain allegedly drug oriented health tonics on the young minds.

4. R. Ahuja, *Sociology of Youth Subculture*, p. 57.

Advertising is a major revenue earner for many sports events. It is significant to observe that several popular sports events are sponsored by, among others, wine and cigarette manufacturing companies. Notable presser of famous cigarettes companies such as Indian Tobacco Co. (I.T.C.), Godfrey & Philips and such wine etc. companies as Mohan Meakin. Besides, million of dollars etc. are spent by so called health tonics manufacturers on organisation of sports and cultural meet especially devoted to the brainwashing of youth. Do such ads offensives not throw in false notion for the unsuspecting youth ? The answer is generally in the affirmatives. Advertising of alcohol products has been unbelievably successful in convincing Indian youth that good times and alcohol are synonymous, that it is normal and healthy to drink and that happiness and alcohol are intimately related.⁵

3. PLACE OF FIRST USE

In the 1976 survey of drug abuse among college/university students in Jaipur city, it was revealed that 33.1 per cent had first taken drugs in a hostel, 17.0 per

5. For effects of advertising of alcohol in American Society, refer to Ken Liska, **Drugs and the Human Body with implications for Society**, p. 244.

cent in a friend's house and 49.9 per cent at some other place. The findings of our study showed that out of 39 past users, 8, 10 and 21 had taken drug while they were studying in middle, senior secondary school and college respectively. 13 past users (3, 4, 6 at the above three levels of their education) i.e. 33.3 per cent altogether and 5, 8 and 45 of current users respectively i.e. 33.1 per cent altogether first experimented with drugs in a hostel, 66.7 per cent at their friends' houses, picnic places, betel shops and recreational centres like movie houses, games and sports meet venues, cultural show places etc. The friends' houses accounted for 37.4 per cent of first use places. In all these cases, it was revealed that the first experience of drug use was made in most of the cases with the support and participation of friends. This reflects our finding that friends play an important role in initiating users to drug behaviour.

If we analyse drug-wise, we find that out of 78 alcohol first users, 43.6 per cent had taken it in a hostel, 32.1 per cent in a friend's house and 24.4 per cent at some other place. Against this, out of 60 users who had started with cigarettes, 16.7 per cent had first smoked in a hostel, 31.7 per cent in a friend's house and 51.7 per cent at some other place. The place of first use for all drugs is shown in Table 5.5

It is evident from this table that drugs recreation, also called "playful" drugs (like alcohol, tobacco etc.) and hard drugs (like L.S.D., Cannabis, Hashish etc.) are mostly started with friends while soft drugs (like tranquilisers, painkillers etc.) are taken either alone (not shown in the table) or with some person other than a friend.

TABLE 5.5

DRUG-WISE PLACE OF FIRST USE BY
THE EVER-USERS IN THE SAMPLE

Drug	No. of Users	Hostel	Friend's house	Other Place
1. Alcohol	78	34 (43.6)	25 (32.1)	19 (24.4)
2. Tobacco	60	10 (16.7)	19 (31.7)	31 (51.7)
3. Painkillers	38	11 (28.9)	18 (47.1)	9 (23.7)
4. Tranquilisers	16	10 (62.5)	6 (37.5)	-
5. Barbiturates	2	2 (100.0)	-	-
6. Amphetamines	6	2 (33.3)	2 (33.3)	2 (33.3)
7. Cannabis	12	2 (16.7)	8 (66.7)	2 (16.7)

TABLE 5.5 CONTD.

Drug	No. of users	Hostel	Friend's house	Other Place
8. Charas	-	-	-	-
9. Hashish	-	-	-	-
10. Marijuana .	-	-	-	-
11. Pethidine/ Morphina	-	-	-	-
12. Heroin	1	-	1 (100.0)	-
13. L.S.D.	1	-	1 (100.0)	-
TOTAL	214 (100.0)	71 (33.3)	80 (37.4)	63 (29.4)

Let us now compare the place of first use of drugs by males with that of females. 18.5 per cent females had first taken drugs in a friend's house, 37.0 per cent in a hostel and 44.5 per cent in some other place, in comparison to 20.0 per cent males in a friend's house, 35.0 per cent in a hostel and 45.0 per cent in some other place. This shows that there is no material difference in the place of first drug use between females and males. Drugwise we find females had also first taken recreational drugs like tobacco and alcohol or tranquilisers at a place

other than a hostel or a friend's house. This further supports our hypothesis pertaining to the significant role of friends in initiation into the abuse of recreational drugs.

4. DRUG OF FIRST USE

According to the popular notion, the drug users generally start with cigarettes and alcohol beverage (recreational drugs) and then switch over to soft drugs and ultimately to hard drugs. Our investigation of current drug users in the sample does not support this notion. When the current drug users (regulars and addicts) were asked whether they had started with the drug they were using at present or with some other drug, 74.5 per cent (28 regulars and 10 addicts) said they had started with the present drug and only 25.5 per cent (10 regulars and 3 addicts) told they had started with some other drug and then moved over to the use of present drug(s).

This indicates that drug abusers do not show a definite ascending use of drugs, typically moving toward the one with the big "kick". However, a different conclusion could have been arrived at had the number of regulars and addicts been sufficiently large among the

current users. Both alcohol and tobacco were found to be forerunners to abuse of other 'soft' or 'hard' drugs in a majority of cases in several other studies. Only in 7 to 12 per cent cases (regulars and addicts) 'sedatives' or 'depressants' and 'stimulants' were detected as forerunners to abuse of opium. Pethidine/morphine, charas, hashish and marijuana, and hallucinogens like L.S.D. It is exceptionally the "spoiled" or "hopeless" drug addicts who dread not to tread on the forbidden path. The multiple drug users usually display the tendency of moving from recreational to soft and then ultimately to hard drugs.

5. CONDITIONS PROMOTING DRUG ABUSE

Most researchers have adopted the motivational approach to the understanding of drug abuse/use. Duesek and girdano, while analysing motivations for smoking, say "most people start smoking for social reasons and continue out of habit or for satisfaction of a psychological need.... most heavy smokers take up the habit before the age of twenty. Smoking fits several of the popular models designed to explain the use and abuse of drugs.

The socio-cultural model explains the drug use from the stand point of meaning and significance a given society assigns to their use and users. It is obvious the initial use of cigarettes by teenagers has less to do with the pharmacology of tobacco and more with the socio-cultural milieu surrounding its use. Smoking, at least in the initial state of the habit, is a sociological phenomenon."⁶

Many of those who have been oriented to smoking by family and/or friends will accept it as a part of their lives. With the advance in age (in adolescence) the social sanctions against smoking are lessened, friendships among smokers and non-smokers become common place. Even though the youngsters are better able to accept individual differences and are more internally motivated, parents, teachers, siblings, and peers still influence many to start smoking. Likewise, one cannot disregard smoking as a symbol of independence or of being grown-up.

The sudden disappearance of these motivations would still leave a very forceful motivation of advertising. Besides, smoking satisfies a need of the

6. Dorothy, E. Duesek and Daniel A. Girdano, **Drugs : A Factual Account**, p. 145.

smoker. Nicotine is a mild stimulant ; thus a slight elevation of mood often results. Also, there may be deeper psychological motivations. Smoking is the abuse of a chemical substance and an abuse of oral gratification, and it usually develops into a habit. Studies on teen-age smokers suggest a relationship between the need to smoke and feelings of insecurity and low esteem smokers continue to smoke primarily because of the perceived benefit (say, for example, stress relaxation) derived from smoking.

Based on the motives for smoking, at least four different types of smokers have been identified : **negative effect smoker** (in times of crisis), **addictive smoker** (moved by strong and persistent desire), **positive-effect smoker** (add to enjoyment and **habitual smoker** (automatic habit)).

This discussion leads us to discount the psychological model of the drug use, which tends to put a major emphasis on the individual as the active agent in the drug individual relationship. Drug use and drug users are a complex, dynamic interrelationship of psychological need and actual or perceived effects of the drug.

physiological conditions - like staying awake, heightening sexual experiences, removing pain, getting sleep, lessening lethargy etc. (2) psychological or personality conditions - like relieving tension, easing depression, removing inhibitions, satisfying curiosity, getting kicks, feeling high and confident, intensifying perception, removing boredom etc. (3) Social conditions - like facilitating social experiences, being accepted by friends, challenging social values, etc. and (4) Miscellaneous conditions - like improving study, sharpening religious insight, deepening self-understanding solving personal problems etc.⁸ 12 to 34 per cent drug users in the sample gave the first group of conditions, 7 to 44 per cent the second group of conditions, 9 to 46 per cent the third group and 11 to 30 per cent the fourth

8. For psychiatric view, see Marie Newswander, **The Drug Addict as a Patient**, Grune and Stratton, Inc. New York, 1956, Chapter 4.

Hence, we would look into some conditions which generally motivate drug abuse among the youth. The factors/conditions that are likely to influence (motivate) a set of people, need not necessarily motivate another set of people in the same manner or magnitude. A distinction between the "possible" and "inevitable" factors must be maintained.

The reports from some prestigious research organisations have listed reasons why youngsters take drugs : to change moods, to feel good, to be accepted by friends, to increase self-reliance, to escape problems and boredom and to appear mature because tobacco, alcohol and drugs are symbols of adulthood.⁷ To be sure, however, to develop an etiology of drug abuse is scientifically unproductive. Instead of much hallowed causation theories, which have of late been abandoned, in social sciences, conditions oriented approach to the analysis of any social phenomenon is considered logically and objectively a more sound approach.

In our study, the drug users revealed that various conditions have motivated them to drug-taking behaviour. We may group these conditions under four heads : (1)

6. Ken Liska, **Drugs and the Humanbody** (with implications for Society), p. 311.

TABLE 5.6

CONDITIONS LEADING TO DRUG-USE IN THE SAMPLE

Conditions	PAST-USERS			CURRENT USERS			Grand Total N=214 8.
	M N-34 2.	F N-5 3.	T N-39 4.	M N-126 5.	F N-49 6.	T N-175 7.	
1. <u>PHYSIOLOGICAL</u>							
i) Staying awake	10 (29.4)	2 (40.0)	12 (30.8)	25 (19.8)	12 (24.5)	37 (21.1)	49 (22.9)
ii) Heighten sexual experiences	8 (23.5)	1 (20.0)	9 (23.1)	10 (7.9)	6 (12.3)	16 (9.1)	25 (11.7)
iii) Remove pain	8 (23.5)	3 (60.0)	11 (28.2)	28 (22.2)	34 (69.4)	62 (35.4)	73 (34.1)
iv) Get sleep	6 (17.6)	2 (40.0)	8 (20.5)	30 (23.8)	18 (36.8)	48 (27.4)	56 (26.2)
2. <u>PSYCHOLOGICAL</u>							
i) Relieve tension, facilitate relaxation	10 (29.4)	2 (40.0)	12 (30.8)	18 (14.3)	12 (24.5)	30 (17.1)	42 (19.6)
ii) ease depression	11 (32.4)	2 (40.0)	13 (33.3)	12 (9.50)	10 (20.4)	22 (12.6)	35 (16.4)
iii) feel good, get high	8 (23.8)	3 (60.0)	11 (28.3)	15 (11.9)	17 (34.7)	32 (18.3)	43 (20.1)
iv) satisfy curiosity	14 (41.2)	3 (60.0)	17 (40.6)	56 (44.4)	18 (36.8)	74 (42.3)	91 (42.5)

1.	2.	3.	4.	5.	6.	7.
v) intensify perception, increase aesthetic awareness	7 920.6)	1 (20.0)	8 (20.5)	18 (14.3)	7 (14.3)	25 (14.3)
vi) for kicks	5 (14.70	1 (20.0)	6 (15.40	7 (5.6)	2 (4.1)	9 (5.1)
3. <u>SOCIAL</u>						
i) facilitate social experience	18 (52.9)	4 (80.0)	22 (56.4)	56 (44.4)	20 (41.0)	76 (43.4)
ii) Get accepted by friends	15 (44.1)	3 (60.0)	18 (46.2)	53 (42.1)	23 (46.9)	76 (43.4)
iii) challenge values of society	6 (17.6)	1 (20.0)	7 (17.9)	10 (7.9)	2 (4.1)	12 (6.9)
4. <u>MISCELLANEOUS</u>						
i) improve studying	8 (23.5)	3 (60.0)	11 (28.3)	44 (34.9)	8 (16.4)	52 (29.7)
ii) sharpen religious insight	5 (14.7)	2 (40.0)	7 (17.9)	13 (10.3)	4 (8.2)	17 (9.7)
iii) deeper self-understanding	6 (17.6)	3 (60.0)	9 (23.1)	18 (14.3)	3 (6.1)	21 (12.0)
iv) solve personal problems	8 (23.5)	2 (40.0)	10 (25.6)	32 (25.4)	7 (14.3)	39 (22.3)

Note : Totals do not add upto 100 per cent due to multiple responses.

group of conditions. Totals add to more than 100 per cent due to multiple responses. The details of conditions leading to drug use in the sample are displayed in Table 5.6.

The figures in the Table 5.6 point out that (1) the largest category of students using drugs comprised carefree individuals devoted to pleasure, seeking new excitement and sensation, (2) a small number took drugs as an escape mechanism or to alleviate distress (tension and depression) and (3) a very small percentage of students receiving drugs in the course of medical treatment for the relief of pain continued to take them long after the treatment was over.

Among physiological conditions, 22.9 per cent students used drugs to keep awake, 11.7 per cent to heighten sound experiences, 34.1 per cent to remove and 26.2 per cent to get sleep. As regards psychological conditions, maximum number of respondents (42.5 per cent) used drugs to satisfy curiosity, about 20 per cent to relieve tension and facilitate relaxation or to feel good and get high, about 16 per cent to ease depression or to intensify perception and increase aesthetic awareness, while only 7 per cent used drugs to get kicks.

In respect of social conditions, highest percentage of respondents (89.7) used drugs to either facilitate social experience or to get accepted by friends, i.e. drugs were regarded by them as stimulants/lubricants to socialisation. Only a very small number (8.9 per cent) thought it wise to use drugs for challenging social values or for circumventing social mores.

While encountering drug abusers, less than one third of them were found having fostered the mistaken belief that use of drugs helped them in improvement of their studying capacity. 22 per cent students averred that drug taking helped them in more quickly solving their personal problems, 14 per cent used drugs for deepening self understanding while only 11.2 per cent used drugs for sharpening religious insight.

The above miscellaneous conditions could, however, not elicit unambiguous or straight-forward responses from our subjects. We feel they needed clearer definitions and/or more realistic classification. Inclusion of cafeteria questions (questions having predeterminate answers) in the questionnaire/interview schedule introduces an element of vagueness.

If we compare the conditions of drug-taking in terms of sex difference, figures in table 5.6 indicate that (1) 38.4 per cent girls take drugs due to physiological conditions compared to 61.6 per cent boys in this category, (2) 30.1 per cent girls use drugs due to psychological conditions compared to 69.9 per cent boys, (3) Due to social conditions 25.1 per cent girls take drugs compared to 74.9 per cent boys, (4) Miscellaneous conditions motivate 19.3 per cent girls compared to 80.7 per cent boys.

Again among girls, 32.3 per cent use drugs for physiological reasons, 32.4 per cent for psychological reasons, 22.0 per cent for social reasons and 13.3 per cent for miscellaneous reasons compared to 21.6, 27.9, 27.3 and 23.2 per cent boys respectively in the above four categories. This shows : (1) Girls in very large numbers take drugs for physiological and psychological reasons (65 per cent in all), whereas only about one-fifth and one-eighth of girls take drugs for social and miscellaneous reasons respectively. (2) About 55 per cent boys take drugs for psychological and social reasons, while nearly one fifth of them use drugs for either

physiological or miscellaneous reasons. (3) Girls used more prescription drugs (mionor tranquilisers, sedatives and anti-depressants etc.) than boys while the reverse was true for over-the-counter drugs (stimulants, sleeping pills etc.).

These findings enable us to question the view⁹ that drug users exhibit a personality type involving strong dependency needs with pronounced feelings of inadequacy. Alfred Lindesmith has provided a detailed critique of the theory of "psychopathic personality" or "psychopathic predisposition". He propounds an alternative theory that the knowledge or ignorance of the meaning of withdrawal distress and the use of drugs thereafter determines whether or not the individual becomes dependent on drugs.¹⁰ We have not tested this theory because while Lindesmith's focus of study was "process of becoming addict", our central theme was "nature and incidence of drug prevalence."

9. For psychiatric view, see Marie Newswander, **The Drug Addict as a Patient**, Grune and Stratton, Inc., New York, 1956, Chapter 4.

10 (i) Alfred, R. Lindesmith, "The Drug Addict as Psychopath", **American Sociological Review**, 1940, p. 920.

(ii) Alfred, R. Lindesmith, "A Sociological Theory of Drug Addiction", **American Journal of Sociology**, 43 (1938) pp. 593-613.

While discussing alcoholism, a theory of specific "alcoholic personality" was enunciated by some social psychologists. However, it was found untenable or invalid. Alcoholics do not constitute a homogenous group. In an unselected group of inebriates, there will be found as many different personality types as there are in the general population. Within the alcoholic group, there is some evidence that individuals, whose addiction is incidental to social drinking over a period of years, show more extroverted or cyclothymic, tendencies than individuals whose addiction is symptomatic of a basic personality imbalance.¹¹

Free availability of alcohol and other drugs is one of the most important reasons of addiction/drug abuse because it is very difficult to resist the temptation when everybody is using it. Resultantly, liquor and cigarettes and "gutakas" have attracted more and more youngsters. Many researchers have assiduously illustrated the interrelationship between the availability of intoxicating beverages and other psychoactive substances and the extent and incidence of prevalence of drug abuse. Blum in his book **"Drug and Society"** (1969) has discussed the social influences on drunkenness.

11. Bhin Sain, **Alcohol Addiction**, H.K. Publishers & Distributors, Delhi, 1989, p. 61.

A survey of the "causes" meaning the conditions promoting drug use, of drug addiction amongst students showed that it may be an escape from a jilted love affair, parental neglect, disinterest in studies and loneliness. There were instances of students becoming addicted to drugs in order to become cult figures on the campus. There is also peer pressures from fellow students. Many drug peddlers pose as vendors and lace foodstuffs with smack/cocaine etc. Thus, many students become addicted without them being even aware of it.¹²

With the help of the above, we want to emphasize that it is most difficult to pinpoint even the major or more important ones, for drug abuse. To us the categorisation of conditions into physiological, psychological, social and miscellaneous groups appears to be rather arbitrary and inadequate representation of reality on the drug abuse scene. Physiological, psychological and miscellaneous conditions of drug abuse have little significance in themselves unless they are mediated through by social-cultural milieu within which the youth (or individuals) are functioning as social beings. The susceptibility of youth to drug usage is determined (or conditioned) by the mode of their contact with a drug.

12. S.K. Ghosh, **The Traffic in Narcotics and Drug Addiction**, Ashish Publishing House, New Delhi, 1987.

Dorothy E. Dusek and Daniel Girdano (in their book **Drugs : A Factual Account**, Asian Books Pvt. Ltd., New Delhi, 1989) have listed the causative factors in alcoholism as (i) physiologico-biochemical factors, (ii) possible genetic factors, (iii) psychological factors, (iv) socio-cultural factors (influences), (v) effects of alcohol and (vi) influence of peers and family. They affirm that the factors associated with prevalence and peer influence. Attitudes about drinking as well as the actual drinking behaviour influence the adolescent. Other factors are academic achievement and religious affiliation and commitment. Adolescent drinkers share a variety of personality and psychosocial characteristics.

The above authors curiosity, spiritual search, pleasure, social alienation, psychological alienation and apathy among motivations to drug use but are willing to concede that these motivations may raise more questions than they answer. They say, perhaps drug abuse is symptomatic of an underlying pathology with which our society is stricken, or perhaps it is an offshoot of a new social consciousness or a backlash against bigness, depersonalisation and technology.

DRUG ADDICTION

Speaking of drug addiction, if contact with a drug results from legitimate medical treatment during the course of illness, addiction seldom occurs. Less than 5 per cent addicts become addicted by this means. Contact with the drug through addict friends as a result of curiosity, association, thrill, pleasure seeking is a much more potent cause of addiction. This fact explains why so many individuals who have personality characteristics similar to those of addicts never become addicted. They do not have addict acquaintances."¹³

Similarly, all the individuals placed in the same physiological, psychological, social or miscellaneous conditions do not necessarily take to drug use. The motivational pattern of drug abuse needs further and still closer scrutiny. If drug use is a barometer of social ills, then we must accept the challenge by analysing the reasons for drug abuse. Accepting certain reasons as final or inevitable would be a blunder.

13. Ibid, p. 48

Reasons	NON-USER (ABSTINENCE)			past-USERS (DISCONTINUANCE)			Grand Total
	M	F	T	M	F	T	
1.	N-80 2.	N-6 3.	N-86 4.	N-34 5.	N-5 6.	N-39 7.	N-125 8.
1. PERSONAL							
i) Not interested or curious	42 (52.5)	4 (66.7)	46 (53.5)	13 (38.2)	4 (980.0)	17 (43.6)	63 (50.4)
ii) Enjoy life fully without using the substance	20 (25.0)	5 (83.3)	25 (29.1)	2 (5.9)	3 (60.0)	5 (12.8)	30 (24.0)
iii) Personal dislike or hatred for the substance	10 912.5	3 (50.0)	13 (15.1)	10 (29.4)	3 (60.0)	13 (33.3)	26 920.8
iv) Non-availability or no access to the substance	10 (12.5)	3 (50.0)	13 (15.1)	4 (11.8)	2 (40.0)	6 915.4	19 (15.2)
2. PHYSIOLOGICAL							
i) Risk of physical/mental danger or deteriorating health	22 (27.5)	4 (66.7)	26 (30.2)	9 (26.5)	4 (80.0)	13 (33.3)	39 (31.2)
ii) Risk of dependence on the substance	16 (20.0)	4 (66.7)	20 (23.3)	5 (14.7)	4 (80.0)	9 (23.1)	29 (23.2)
iii) Due to having a bad trip	8 (10.00)	2 (33.3)	10 (11.6)	2 (5.9)	1 (20.0)	3 (7.7)	13 (10.4)
3. SOCIAL							
i) Influence of parents	23 (28.6)	3 (50.0)	26 (30.2)	14 (41.2)	3 (60.0)	17 (43.6)	43 (34.4)

1.	2.	3.	4.	5.	6.	7.	8.
ii) Influence of friends	10 (12.5)	2 (33.3)	12 (14.0)	8 (23.5)	2 (40.0)	10 (25.6)	22 (17.6)
iii) Risk of social disapproval	10 (12.5)	3 (50.0)	13 (15.1)	6 (17.6)	3 (60.0)	9 (23.1)	22 (17.6)
4. <u>RELIGIOUS</u>							
i) Respect for religious techniques	21 (26.3)	2 (33.3)	23 (26.70)	15 (44.1)	3 (60.0)	18 (46.2)	41 (32.8)
5. <u>ETHICAL</u>							
i) As a matter of moral principals	19 (23.8)	2 (23.3)	21 (24.4)	14 (41.1)	2 (40.0)	16 (41.0)	37 (29.6)
6. <u>ECONOMIC</u>							
i) Due to the substance being two expenses	8 (10.0)	2 (33.3)	10 (11.6)	6 (17.6)	2 (40.0)	8 (20.5)	18 (14.4)

6. REASONS FOR ABSTINENCE

Perhaps it may be a little more illuminating to analyse the reasons for abstinence from drugs. Why did the non-users in our sample abstain from taking drugs or the past-users discontinue them ? The analysis showed that the important reasons for abstinence and discontinuation were : personal, social, religious, ethical and economic. The detailed reasons given by the non-users and past-users in the sample are given in Table 5.7

The figures in table 5.7 point out that in 36.3 per cent cases, reasons for abstinence/discontinuance were personal, in 21.4 per cent social, in 22.9 per cent physiological, in 10.8 per cent religious, in 9.7 per cent ethical and in 4.7 per cent economic. Totals add upto more than 100 per cent due to multiple responses.

Comparing the reasons for obstinence/discontinuance by the males with those of females, it was found that 36.0 per cent girls abstained for personal reasons as against 33.9 per cent boys, 25.3 per cent girls for physiological reasons as against 19.0 per cent boys, 21.3 per cent girls for social reasons as against 21.7 per cent boys and 12.0 per cent girls for religious/ethical

reasons as against 21.1 per cent boys. In regard to economic reasons, there was no significant difference based on sex. This shows that the reasons for abstinence/discontinuance vary on the basis of sex (4.7 per cent for girls and 4.3 per cent for boys).

The data of table 5.7 can also be used to classify drug users into four groups.¹⁴

1. Pleasure seekers : Who take drugs to satisfy pleasurable desires.
2. Accidental or Medical : Who learn the usage during the period of sickness to relieve pain and strain. The relief the drug brings calls for its use in relieving further strain.
3. Socially processed : Who take drugs to improve study, to deepen self-understanding, to facilitate relaxation and to solve personal problems etc.
4. Rebels : Who take drugs to experience a sense of liberation from conventions.

Dr. Ahuja claims that his types are "empirical" and not "heuristic" or "ideal" and says that a typology such as described above is likely to encounter certain

14. This has been done following R. Ahuja in **Sociology of Youth Sub-Culture**, p. 72.

objections. He argues that these objections can be avoided if the "purpose" these types intend to serve is clarified. These types serve empirical purpose. According to him, an empirical typology is derived primarily from data rather than from theory ; it functions to summarise observations rather than to enhance vision or to illustrate the existence of essences ; it describes modal rather than extreme characteristics and stands logically between observation and reformulation of theory.¹⁵

Since Ahuja's typology is empirical and is warranted from a study of the data, the objections usually labelled at theoretical typologies, would not be valid in this case. Our typology is the same and formulated in the same manner. Hence any objections against will not be valid. The above categorisation has a basis other than that given by psychiatrists.

Some psychiatrists have classified drug users, for example, on the basis of personality characteristics as emotionally immature, impulsive, angry, shy, seclusive (schizoids) and depressed, alienated etc. Dr. Kenneth

15. Also refer to R.F. Winch, "Heuristic and Empirical Typologies : A Job for Factor Analysis", **American Sociological Review**.

Keniston, a Yale University Psychologist, has divided drug users into three types on the basis of the incidence of drug use : (1) **The Tasters** - Individuals who have tried one or more drugs and have no plans to continue. They constitute the largest group of the users. (2) **The Seekers** - Persons who use drug occasionally for "kicks" and who plan to continue their lives around drugs. (3) **The Heads** - Persons who are the "hard core" addicts, for whom drug use and drug group have become an exclusive or dominating concern or activity. They constitute a considerably smaller group.¹⁶

TYPOLGY OF DRUG ABUSERS

This typology is not different from what is usually adopted for analysing the frequency of drug abuse (intensity of drug abuse) viz. the experimenters, the regulars and dependents (or addicts). The psychologists' description of the great majority of addicts as suffering from character disorders should not be valid for the experimenters and the regulars. It may be true that a

16. Kenneth Keniston, in his article in **Youth and The Drug Problem** by Harold D. Love, p. 8.

majority of addicts are immature, inadequate, passive, aggressive and maladjusted individuals. Teenage narcotic addiction is often associated with introduction of membership in delinquent gang where the use of narcotics is part of gang culture. Following Ahuja, we have classified the users on the basis of factors conditions that lead them to drug usage.

7. PROBLEMS OF DRUG USE : PRIOR KNOWLEDGE NO DETERENT

It was surprising to find that 77.6 per cent users in the sample had taken drugs in spite of knowing that drugs would create dependence psychological and/or physical. When asked why they had taken the risk of getting dependent/addicted, 69.2 per cent past users, 47.4 per cent regulars and 38.5 per cent addicts replied, they were confident of not becoming habituated to drug use, while 25.7 per cent past users, 18.4 per cent regulars and 7.7 per cent addicts said they were persuaded/forced by their friends to use them. The other reasons given were : (i) to solve overwhelming problems (7.9 per cent regulars, 30.8 per cent addicts and 0.0 per cent past users), (ii) drugs taken were not addictive (7.9 per cent regulars, 0.0 per cent past users and 0.0 per cent addicts), (iii) they

just wanted to try how it felt to be addicted (0.0 per cent past users, 7.9 per cent regulars and 15.4 per cent addicts) and, (iv) they were victims to disinformation, that is, their reasoning power was overpowered by "myths" about drugs (5.1 per cent past users, 10.5 per cent regulars and 7.7 per cent addicts). These responses are displayed in Table 5.8.

TABLE 5.8

REASONS FOR TAKING DRUGS AT
THE RISK OF GETTING DEPENDENT

Reasons, given	Past users	Regulars	Addicts	Grand Total
1. Confident of not becoming habituated	27 (69.2)	18 (47.4)	5 (38.5)	50 (55.6)
2. Persuaded/ forced by friends	10 (25.7)	7 (18.4)	1 (7.7)	18 (20.0)
3. Solving over- whelming problems	-	3 (7.9)	4 (30.8)	6 (6.7)
4. Drugs taken were not addictive	-	3 (7.9)	-	3 (3.3)
5. Wanted to feel addicted	-	3 (7.9)	2 (15.4)	5 (5.6)
6. Victims of disinformation	2 (5.1)	4 (10.5)	1 (7.7)	5 (5.6)
TOTAL	N 39 (100.0)	N 38 (100.0)	N 13 (100.00)	N 90 (100.0)

After using drugs, 28.5 per cent users (47 males and 14 females) agreed facing problems caused by drug use while 71.5 per cent (113 males and 40 females) said they did not face problems. Of the 61 users who faced problems (10 past users, 38 regulars and 13 addicts), 65.6 per cent referred to physiological problems (affects health), 24.6 per cent to social problems (affects daily routine and/or social and personal relations and deprives of friends), 6.6 per cent to legal problems (creates troubles with law), 3.3 per cent to economic problems (leaves very little money to spend).

TABLE 5.9

PROBLEMS FACED BY DRUG USERS

Problems faced by Drug users	Past users	Regulars	Addicts	Grand Total
1. <u>PHYSIOLOGICAL</u>				
i) Effects Health	2 (80.0)	23 (60.5)	9 (69.2)	40 (65.6)
2. <u>SOCIAL</u>				
i) affects daily routine	2 (20.0)	11 (28.9)	2 (15.4)	15 (24.6)
ii) affects social relations	1 (10.00)	4 (10.5)	1 (7.7)	
iii) affects perso- nal relations	1 (10.0)	3 (7.9)	1 (7.7)	
iv) deprives of friends	-	2 (5.3)	-	

TABLE 5.9 (CONTD.)

Problems faced by Drug users	Past	Regulars	Addicts	Grand Total
3. <u>LEGAL</u>				
i) Creates troubles with law	-	3 (7.9)	1 (7.7)	4 96.6)
4. <u>ECONOMIC</u>				
i) leaves very little money to spend.	-	1 (2.6)	1 (7.7)	2 (3.3)
TOTAL	N 10	N 38	N 13	N 61

The **first reactions** to drug intake also varied. Of the 214 users in the sample, 44.9 per cent felt excited, 36.9 per cent drowsy, 15.0 per cent suffered from vomiting, 12.6 per cent from headache, 9.8 per cent from giddiness and 9.8 per cent from depression, 7.5 per cent had pleasant visual hallucinations, 10.3 per cent increased sexual excitement (See Table 5.10). Totals are more than 100 per cent due to multiple reactions.

TABLE 5.10FIRST REACTIONS OF USERS TO DRUG-INTAKE

Reactions	Past users	Current users	Ever users
1. Felt excited	18 (46.2)	78 (44.60)	96 (44.9)
2. Felt drowsy	15 (38.5)	64 (36.6)	79 (36.9)
3. Suffered from vomiting	6 (15.4)	26 (14.9)	32 (15.0)
4. Suffered from headache	5 (12.8)	22 (12.6)	27 (12.6)
5. Suffered from giddiness	4 (10.3)	17 (9.7)	21 (9.8)
6. Felt depressed	4 (10.3)	17 (9.7)	21 (9.8)
7. Had pleasant visual halluci- nation	3 (7.7)	13 (7.4)	16 (7.5)
8. Increased confi- dence	4 (10.3)	18 (10.3)	22 (10.3)
9. Increased sexual excitement	3 (7.7)	13 (7.4)	16 (7.5)
TOTAL	N 39 (100.00	N 175 (100.00	N 214 (100.0)

8. PAST-EFFECT REACTIONS

After the effect of the drug-intake had worn out, 16.6 per cent users (7 past users, 6 regulars and 2 addicts) had felt guilty, 35.6 per cent (22 past users, 8 regulars and 2 addicts) resolved not to take it again, 16.6 per cent (10 past users, 4 regulars and 1 addict) declared their intention to take it less frequently, 15.6 per cent decided to continue taking the same quantity and 15.6 per cent wanted to take it more often i.e. increase its frequency (See Table 5.11)

TABLE 5.11

POST EFFECTS REACTIONS OF DRUG USERS

S.NO.	POST EFFECT REACTIONS	PAST USERS	REGULARS	ADDICTS	TOTAL
1.	FELT GUILTY	7 (17.9)	6 (15.8)	2 (15.4)	15 (16.6)
2.	RESOLVED TO DISCONTINUE	22 (56.4)	8 (21.1)	2 (15.4)	32 (35.6)
3.	INTENDED TO DECREASE FREQUENCY	10 (25.6)	4 (10.5)	1 (7.7)	15 (16.6)
4.	WANTED TO INCREASE FREQUENCY	-	10 (26.4)	4 (30.8)	14 (15.6)
5.	DECIDED TO CONTINUE SOME QUANTITY		10 (26.4)	4 (30.8)	14 (15.6)
TOTAL		N = 39 (100.0)	N = 38 (100.0)	N = 13 (100.0)	N = 90 (100.00)

These figures show that in the case of past users, 100 per cent reacted to intake of drugs unfavourably, while unfavourable reaction was in 47.4 per cent regulars and in 38.5 per cent addicts. Both regulars and addicts evidenced more weakness for drugs compared to past users.

9. FATE OF POST-EFFECT REACTIONS

Not all the drug users maintained these reactions. The fate of them varied with the intensity of drug habituation. Both regulars and addicts showed the weakness of their resolves and intentions (See Table 5.12).

TABLE 5.12

FATE OF POST EFFECT REACTIONS

S.NO.	FATE OF P.E. REACTIONS	PAST USERS	REGULARS	ADDICTS	TOTAL
1.	STUCK TO DISCONTINUANCE DECISION/DECREASING FREQUENCY	32 (82.1)	4 (10.5)	1 (7.7)	37 (41.1)
2.	REMAINED UNDECIDED FOR SIX MONTHS	7 (17.9)	14 (36.8)	4 (30.8)	25 (27.8)
3.	FINALLY DISCONTINUED / CONTINUED	7 (17.9) DISCONTINUED WHO HAD FELT GUILTY	14 (36.8) CONTINUED (GUILTY & UNDECIDED)	4 (30.8)	25 (27.8)
4.	KEPT FREQUENCY AND DOZE UNCHANGED	-	4 (10.5)	1 (7.7)	5 (5.6)
5.	INCREASED FREQUENCY AND DOZE	-	16 (42.1)	7 (53.8)	23 (25.6)
TOTAL		N = 39	N = 38	N = 13	N = 90

Thus, we find that out of 32 post users who resolved to discontinue or intended to decrease frequency, 100 per cent stuck finally to their decision/intention compared to only 33.3 per cent regulars and 20 per cent addicts who stuck to their decision/intention. They did not resume taking drugs either because of their bad effect on health (76.5 per cent males and 40 per cent females), or because the drugs were too expensive (41.8 per cent males and 20.0 per cent females) or for fear of developing dependence (5.9 per cent males and no females), or because they had satisfied their curiosity and had no intention to continue (5.9 per cent males) or because of the influence of parents, social pressure/friends' advice (40 per cent females only).

The regulars and addicts, who continued to take drugs, said they did so (i) to try again, (ii) to get needed relief, (iii) to cope with new situations and (iv) to keep pace with the existing fashion.

10. FREQUENCY AND DOSE INCREASE BY REGULARS AND ADDICTS

Of the 46 (90.2 per cent) regulars and addicts who continued taking drugs, 50 per cent found it necessary to increase the quantity while 50 per cent increased the frequency of the intake. Of the 23 cases who increased the

quantity, in 69.6 per cent cases the dose was doubled, in 21.7 per cent cases trebled and in 8.7 per cent cases it was increased four or more times. Of the 23 cases who increased the frequency, in 65.2 per cent cases it was doubled, in 26.0 per cent cases. Trebled and in 8.7 per cent cases it was increased to four or more times.

The 7 addicts, who increased the frequency and quantity of drug intake, felt that they could not live without drugs. Of these 3 were addicted to tobacco and alcohol, 2 to tranquiliser and tobacco, 1 to tranquiliser, alcohol and tobacco and 1 to charas, hashish, alcohol and tobacco.

TIME OF DRUG USE AND AFTER USE ACTIVITY

When asked at what time they took drugs usually and after drug use what was their usual activity, a variety of responses were elicited. Of the 38 regulars and 13 addicts who were currently using drugs, 39.2 per cent had no fixed time for taking them, 29.4 per cent took them only in the evening, 21.6 per cent either before going to bed or getting up in the morning and 9.8 per cent before or after the studies, the work or the meals (See Table 5.13).

TABLE 5.13TIME OF TAKING DRUGS

S.No.	Time	Regulars	Addicts	Total
1.	No fixed time	11 (28.9)	3 (69.2)	20 (39.2)
2.	only in the evening	13 (34.2)	2 915.4)	15 (29.4)
3.	Before going to bed or getting up in the morning	10 (26.3)	1 (7.7)	11 (21.6)
4.	Before/after studies work/meals	4 (10.5)	1 (7.7)	5 (9.8)
TOTAL		N =38 (100.00	N = 13 (100.0)	N = 51 (100.0)

After taking the drugs, out of 51 regular and addict, current users, 11 users (males only) i.e. 21.6 per cent) lay in bed, 8 users (males only) i.e. 15.7 per cent listened to music or just sat idle and 32 users (20 males and 12 females) i.e. 62.7 per cent continued to perform their routine roles like studying, working or playing etc. This shows that drugs, even in the case of regulars and addicts, affect daily routine in 37.2 per cent cases only (See Table 5.14).

However, taking addicts separately it was found that in their case drug taking affects daily routine in 77.0 per cent cases.

TABLE 5.14

ACTIVITIES AFTER DRUG USE

S.No.	Activity	Regulars	Addicts	Total
1.	Lay in bed	5 (13.2)	6 (26.2)	11 (21.6)
2.	Listened to music or sat idle	4 (10.5)	4 (30.8)	8 (15.7)
3.	Continued to perform routine roles	29 (76.3)	3 (23.0)	32 (62.7)
TOTAL		N = 38 (100.00)	N = 13 (100.0)	N = 51 (100.0)

11. WITHDRAWAL SYNDROME

Now, the questions which need some attention are :
Were any attempts made by the drug users to withdraw or abstain from drugs ? If yes, how did they feel in doing so
What distress symptoms (abstinence syndrome/withdrawal syndrome) were experienced by them ?

Of the 51 current users (38 regulars and 13 addicts) in the sample, 14 users (11 males and 3 females) attempted to withdraw from drugs i.e. 27.5 per cent and 37 users (27 males and 10 females) i.e. 72.5 per cent did not make any attempt to withdraw. Speaking of regulars and addicts separately, 28.9 per cent regulars and 23.1 per cent addicts attempted to withdraw i.e. less number of addicts compared to regulars attempted to withdraw.

Of the 51 regulars and addicts, 5 (4 males and 1 female) i.e. 13.2 per cent thought it was easy to withdraw from drugs, 6 (5 males and 1 female) i.e. 15.8 per cent considered it a little difficult, but all of them attempted to withdraw and they were all regulars. Only 3 addicts (2 males and 1 female) i.e. 23.1 per cent, who considered it difficult to withdraw made an attempt at withdrawal, 10 regulars (6 males and 4 females) i.e. 26.3 per cent, who considered it difficult, 11 regulars (9 males and 2 females), 28.9 per cent who thought it very difficult alongwith 2 females addicts i.e. 15.4 per cent and 6 regulars (5 males and 1 female) i.e. 15.8 per cent and 8 male addicts i.e. 61.5 per cent, who thought it impossible, did not attempt to withdraw. These figures are displayed in Table 5.15.

TABLE 5.15

**HOW THE DRUG USERS FELT
WHEN WITHDRAWAL ATTEMPT MADE**

S.NO.	THE WAY THEY FELT	PAST USERS	CURRENT USERS		
			REGULARS	ADDICTS	TOTAL
1.	IT WAS EASY	28 (71.8)	5 (13.2)	-	5 (9.8)
2.	A LITTLE DIFFICULT	6 (15.4)	6 (15.8)	-	6 (11.8)
3.	DIFFICULT	3 (7.8)	10 (26.3)	3 (23.1)	13 (25.5)
4.	VERY DIFFICULT	2 (5.1)	11 (28.9)	2 (15.4)	13 (25.5)
5.	IMPOSSIBLE	-	6 (15.8)	8 (61.5)	14 (27.5)
TOTAL		39 (100.0)	38 (100.0)	13 (100.0)	51 (100.0)
6.	ATTEMPTED TO WITHDRAW	39 (100.0)	11 (28.9)	3 (23.1)	14 (27.5)
7.	NOT ATTEMPTED	-	77 (71.1)	10 (76.9)	37 (72.5)
TOTAL		39 (100.0)	38 (100.0)	13 (100.0)	51 (100.00)

On the other hand, of the 39 past users (who were not taking drugs currently), 71.8 per cent had considered it easy to give up drugs, 15.4 per cent a little difficult 7.8 per cent difficult, 5.1 per cent very difficult and none found it impossible. But the fact that since not only 87.2 per cent in the first two groups but even the 12.8 per cent in the last three groups were not taking drugs any more indicated that they had succeeded at their withdrawal attempt. Why then did the current users fail in their attempt of withdrawal may perhaps be attributed to personality differences.

Of the 51 current users (38 regulars and 13 addicts) who attempted to withdraw 50.0 per cent felt restless on withdrawal attempt, 14.3 per cent suffered from headache, 14.3 per cent from nervousness, 7.1 per cent from muscular pain, and 7.1 per cent from stomachic tamps, 7.1 per cent suffered in some other way. On this basis, we could say, all current users who made withdrawal attempts felt that the attempt led to some small or severe distress, often to misery and agony. The distresses experienced were both somatic and psychological, their severity being replated to the nature of drug withdrawn, from the daily dosage used and the intervals, the duration

of drug was withdrawn from and the intensity of dependence. In other words, the withdrawal syndrome had both an organic and psychological basis.¹⁷ Given current guidance and help, a large number of these dependents can surely be rescued.

TABLE 5.16

WITHDRAWAL SYMPTOMS

Symptoms	CURRENT USERS		
	Regulars	Addits	Total
1. Felt restless	7 (63.6)	-	7 (50.0)
2. Suffered from headache	2 (18.2)	-	2 (14.3)
3. Nervousness	1 (9.1)	-	2 (14.3)
4. Muscular pain	-	1 (33.3)	1 (7.1)
5. Stomach ctamps	-	1 933.3)	1 (7.1)
6. Others	1 (9.1)	-	1 (7.1)
TOTAL	N = 11 (100.0)	N = 3 (100.0)	N = 14 (100.0)

16. our findings are supported by those of Dr. Ram Ahuja's 1976 and 1986 surveys.

Of those 14 current users who did try to withdraw from drug usage, 14.3 per cent did not take it for 6 months to 1 year and 57.1 per cent for one month to six months. However, all those users ultimately felt the overpowering desire and compulsion to revert to drug intake.

Again, taking tobacco and alcohol use separately from the use of other drugs and analysing withdrawal attempts on the basis of sex, we find significant differences based on sex, as it is shown in Table 5.17.

TABLE 5.17

WITHDRAWAL ATTEMPTS BY DRUG USERS
(REGULARS & ADDICTS)

In terms of sex differences, 66.7 per cent females in comparison to 72.7 per cent males tried to keep off from smoking, 100.0 per cent females in comparison to 68.8 per cent males attempted to get rid of alcohol taking habit, and 82.3 per cent females in comparison to 56.7 per cent males attempted withdrawal from other drugs. Thus since 83.3 per cent females appeared to be keen in relation to 69.2 per cent males to skip off the habit, it may be pointed out that the girls made more withdrawal attempts than the boys.

To sum up, the above analysis of motivations points out there is no single motive or reason, for drug abuse, as there is no single type of drug user. Drug habit is a product both of the social environment and his own personal characteristics. Particularly, the family and the peer group constitute his social environment in which the student lives. His personal characteristics include his goals, attitudes, interests, temperament and adjustive efficiency. Our study does not support Laurie's view¹⁸ that students take drugs as a means of finding their sense of identity. He

17.

Peter Laurie, **Drugs : Medical, Psychological and Social Facts**, Penguin Books, Maryland, 1969, pp. 49-50.

suggested that this motive is most compelling for those inadequate, unsure standardless personalities who seem to be particularly susceptible to drug use. Our drug users in the sample do not possess this type of personality. Our study also does not indicate that drug abuse is a symptom of some need and that it is more troubled or the more disadvantaged situationally who are likely to take up drugs. These findings find their support in the results of national empirical surveys of drug use among college and university students.

However, it is important to recognise at this stage that drug abuse is a learned behaviour which is learnt by students (and for that matter any individual) in interaction with family members, peers, acquaintances and others through the processes of persuasion, reflective thinking and unconscious imitation.

The four types of drug users identified earlier on the basis of reasons for drug taking, viz., pleasure - seekers, social processed, medical or accidental and rebels or the three types of users developed on the basis of "initiative incentive", viz., self-directive,

submissive and adaptive, learn drug taking through any one or more of these processes. An attempt at developing a theoretical explanation in this context has been made in the concluding chapter. In the next chapter (6), we propose to analyse the social environment of drug-users, particularly the role of family and peer group in drug-taking behaviour.

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CHAPTER - VI

THE FAMILY AND PEER GROUP - THEIR ROLE IN DRUG USAGE



लोग नशीले पदार्थों से बचें : वेंकटरामन

कलकत्ता, १ दिसम्बर (वार्ता)। राष्ट्रीय रामस्वामी वेंकटरामन ने मारुत द्रव्यों के इस्तेमाल से होने वाले नुकसान के बारे में लोगों को आगाह करने की आवश्यकता पर जोर देते हुए कर्नाटकी संगठनों से समाज को नशीले पदार्थों से बचने को कहा है।

राष्ट्रपति ने मारुत द्रव्यों पर यहां तीन दिन के अन्तरराष्ट्रीय सम्मेलन को भेजे गये संदेश में कहा कि नशीले पदार्थों से अपराध को बढ़ावा मिल रहा है।

इंडियन कैम्बर आफ कमर्स के मारुत द्रव्य दुष्प्रभाव रोकथाम प्रकोष्ठ ने सम्मेलन का आयोजन किया है। सम्मेलन में आज कहा गया कि विश्व को मारुत द्रव्यों से मुक्त करने के लिए संयुक्त कार्रवाई की जरूरत है।

सम्मेलन का उद्घाटन करते हुए केन्द्रीय समाज कल्याण मंत्री सीताराम केसरी ने विश्व को नशीले पदार्थों से मुक्त करने के लिए अन्तरराष्ट्रीय सहयोग बढ़ाने तथा सरकारी और गैर सरकारी संस्थाओं एवं संगठनों के संयुक्त अभियान की आवश्यकता पर बल दिया।

श्री केसरी ने कहा कि भारत ऐसे विक्रमों के बीच स्थित है जहां डेट्रिमेंट का सबसे

अधिक उत्पादन होता है। इसलिए देश नशीले पदार्थों के अवैध धंधे का मुख्य आयातक बन गया है।

उन्होंने कहा कि सरकार मारुत द्रव्यों के अवैध धंधों को रोकने के लिए बहुमुखी नीति बना रही है। समाज कल्याण मंत्रालय नशीले पदार्थों की समस्या की तह तक जाने के लिए जल्दी राष्ट्रव्यापी सर्वेक्षण भी करेगा।

CHAPTER - VI

THE FAMILY AND PEER GROUP - THEIR ROLE IN DRUG USAGE

1. INTRODUCTION

Sociologists explain human behaviour as a result of the interplay between the individual and his society. It is the compromise and balance which the individual must accept for himself if he is to be socially acceptable, effective and personally satisfied. It is the relatively constant pattern of behaviour he has learned to employ in order to cope with the interplay of forces from within and without. Erratic and fortuitous behaviour of individuals is generally discouraged by society. There is an extremely rich continuum of socially accepted, unaccepted, acceptable and not so acceptable behaviour patterns to which all individuals are induced or compelled to conform during the intricate and variegated process of socialisation.

This process not only enables them to respond effectively and satisfactorily to generally normal and predictable situations but also inculcates in them the sense and capability to respond to even unforeseen and/or imponderable situations which may arise in the course of their life. Thus, individuals are, in most cases, with

only very rare exceptions, "prepared" to meet all eventualities. In fact, all modes and varieties of behaviour fall within the social vortex of learned behaviour. But it is also a fact that all learned behaviour does not conform to the conventional mode. Both conventional behaviour patterns as one side and unconventional or non-conventional and anti-conventional behaviour patterns. On the other side exist in society simultaneously. The unconventional etc. ones are labelled as "deviant" forms.

Thus, to deviate from the prescribed norms is labelled not merely 'bad' but dangerous and damaging. On occasion society is right in its rhetorical forensics : some forms of unconventional behaviour are associated with "objective" damage. "But more often these "rational" grounds, often supported by science and psychiatric medicine, for not participating in activities that society condemns serve as a repressive device, a mechanism designed to alienate men and women from the full range of being that they could be".¹ With the growth of deviant sub-cultures in a complex and fast changing society efforts at social control and socialisation have become increasingly ineffective.

1. Erich Goode, *Drugs in American Society*, p. 232.

As pointed out earlier, an individual's behaviour is the compromise and balance which he must accept for himself, if he is to be socially acceptable, effective and personally satisfied. Since his progress towards such a compromise and balance is largely dependent upon "adjustment" (and not "submission") to forces already existing in the social system, his family and peer group associations are the primary potent influences upon the direction he takes and maintains or modifies during his life. Family provides his first problem in social living followed by friendship circle. Within the family group the individual becomes sensitive for the first time to social needs while from the friendship group he takes important cues for action which develops into character.

It is, therefore, necessary for proper understanding of drug taking behaviour to examine the role of family and peer group in it. In attempting to understand how hostel inmates (as a sub-category of students) are induced to drug use, we shall start with their families first.

2. ROLE OF THE FAMILY

The family plays an important role in drug-use explanation in two ways. In one theoretical explanation, the family is viewed as a potential source of stress for the young person who may turn to drugs to cope with this stress (conversely, an "affectionate" family may act as a deterrent to a youth's use of drugs). Another theory states that the family may act as a model for the youth to emulate.

Explaining the correlation between drug use and family life, Graeven and Schaef² refer to a type of family which consists of those factors considered necessary to provide an optimum environment for childhood growth and development. Such a family has the following characteristics :

- i) not broken by conflict, separation, desertion or divorce ;
- ii) contains a high degree of emotional cohesion ;
- iii) has a high degree of supportive interaction ;

2. Graven and Schaef "Family Life and levels of involvement in an adolescent heroin epidemic, "International Journal of Addictions, 1978, 135 pp.

- v) provides a positive adolescent evaluation of the parent ;
- v) possesses high behavioural integration ; and
- vi) has low amount of conflict and external control.

Families lacking in these areas are more likely to produce an adolescent (or youth) who becomes involved in deviant behaviour, including drug use. Ram Ahuja has called Graeven and Schaef's type of family "the affectionate family".

Is there any empirical support for the above mentioned two theoretical viewpoints ? To find an answer, we will have to test empirically the two hypotheses :

1. The drug usage is influenced by the quality of "affectional family relationships" i.e. on affectionate family may act as a deterrent to an adolescent's (youths) use of drugs ; and
2. The children in families where there is a drug abuse problem have greater chance of involvement with drugs than those from families without this problem.

Let us first attempt to test the first hypothesis. Two things were considered important in this type of analysis, to devise an instrument for the measurement of affectional relationships within the family ; and second, to determine the extent to which affectional family relationships influence the drug usage.

Dr. Ram Ahuja decided to study family structure and family control to secure data on family relationships. According to him, the analysis of these two factors could be adequately used to explain relationship between family environment and drug usage in one of the following two ways ; (i) drug use arising out of family problems ; and (ii) drug use causing family problems. He confined his investigation to the first view because in his surveys intensive study of large number of 'addicts' to analyse the second view was not included.

To test the above mentioned first hypothesis he operationalised the term "affectional family relationships" and listed the conditions believed necessary for "normal" families or for good affectional relationships in the family. They are as follows :

1. Parents take interest in the career of their children and are conscious of their parental obligations.
2. The relations between father and mother of drug users, between drug users and their patterns, and between users and their siblings are based on solidarity.
3. Parental control is neither very harsh nor very lenient so as to give an opportunity to the child for self expression.
4. The size of the family is so manageable in terms of family income that no child in the family suffers from unfulfilment of the necessities of life.
5. Parents broadly conform to social and moral norms setting examples for their children to follow.
6. The child exhibits a feeling of trust and security in the parents by taking them into confidence and by going to them for advice and help with regard to perplexing problems he/she faces.

According to Dr. Ahuja, this operational definition of "normal family" or "affectional family relationships" thus covered nine areas of family life :

- i) interparental relations, (ii) parent-children relations, (iii) inter-sibling relations, (iv) signs of tensions, (v) parental interest in children, (vi) trust and faith by parents in children, (vii) trust and faith by children in parents, (viii) home standards and (ix) confidence shared.³

a) Staying away from Parents

Does our data establish any relationship between drug use and home staying of the users ? This could not be found since our total sample comprised hostel inmates. However, some other studies have found that residence with parents has significant influence on drug usage. Staying away from parents (living in hostels, rented rooms or lodges) leads to comparatively less control over students' behaviour. This shows that residence with parents is as much important in the incidence

3. R. Ahuja, op. cit. p. 83

of drug usages as residence in hostel etc. The hypothesis that the incidence of drug usage and staying away from parents or with parents are independent attributes is incorrect.

What is the significance of family background in drug usage ? To get an answer we will have to analyse the family status of the drug users and examine the relationship between family environment and drug usage. For accomplishing this task we considered it useful to adopt Ram Ahuja's scheme mentioned above and analysed various aspects of drug users' families.

b) Family Structure

Out of 214 cases of drug users, in 87.4 per cent cases both parents of drug users were found alive, in 7.0 per cent cases only mother was alive and in 5.6 per cent cases only father was alive ; in no case both parents were found dead or living separately due to judicial separation, desertion or divorce.

TABLE 6.1FAMILY COMPOSITION OF DRUG USERS AND NON-USERS

Family Composition 1.	Non- users 2.	Past users 3.	Current users 4.	Total (3+4) 5.
1. Both parents alive	74 (86.1)	34 (87.2)	153 (87.4)	187 (87.4)
2. Only mother alive	7 (8.10)	3 (7.7)	12 (6.9)	15 (7.0)
3. Only father alive	5 (5.8)	2 (5.1)	10 (5.7)	12 (5.6)
4. Parents dead/ separated/ divorced	-	-	-	-
GRAND TOTAL	N = 86 (100.0)	N = 39 (100.00)	N =175 (100.0)	N =214 (100.00)

It has been established in family studies that loss of a parent through death (or long incarceration staying abroad or within the country away from the family for long periods) deprives the child of love, affection and care. Where the female parent is missing, the child is placed under obvious emotional handicap. Absence of mother causes certain affectional loss for the child. Where male

parent is absent, the control, example and guidance given by the father is wanting and complete satisfaction of the child is rendered more difficult. Our study showed that the percentage of drug usage increases from 5.6 where the mother is dead and the child is with his father, to 6.5 where the father is dead and the child is with his mother and to 87.9 where both parents are living together. The comparative analysis of boys and girls separately shows the same pattern. This indicates that the emotional handicap due to mother's death or control problem due to father's death creates a problem for the child which may lead him to deviant behaviour like drug usage.

c) Inter-parental Relations

Do inter-personal relations between children's parents have their impact on the incidence of drug usage in children ? For an understanding of this aspect, we analysed the intra-family relations. Since the composition of family, its structure (nuclear or joint) and the marital status of its

members, besides, some other things, affect the intra-family relations, we analysed the composition and structure of the families of drug users and their marital status.

- i) **Family Structure** : 75.2 per cent drug users (past and current together) were found living in nuclear families compared to 24.8 per cent living in joint families. In contrast to this, of the 86 non-users, 76.7 per cent were found living in nuclear families and 23.3 per cent in joint families. Since 7.5 out of every 10 drug users were from the nuclear families in comparison to 7.6 out of every ten non-users in the nuclear families, we could not attach much importance to the structure of drug users' families as a contributory factor in drug usage (See Table 6.2).

TABLE 6.2FAMILY STRUCTURE OF USERS AND NON-USERS

Type of family	Non-users	Past users	Current users	Total
Nuclear	66 (76.7)	30 (76.9)	131 (74.8)	227 (75.7)
Joint	20 (23.3)	9 (23.1)	44 (25.2)	73 (24.3)
TOTAL	N == 86 (100.00)	N = 39 (100.0)	N = 175 (100.00)	N = 300 (100.00)

161 (75.2 per cent) everusers lived in nuclear families and 53 (24.8 per cent) in joint families.

The chi-square also disproved our null hypothesis (that there is association between family structure and drug use) as shown in Table 6.3)

TABLE 6.3CORRELATION BETWEEN TYPE OF FAMILY & DRUG ABUSE

Type of family	Non-users	Ever-users	Total
Nuclear family	66	161	227
Joint family	20	53	73
	86	214	300

Obtained x^2 = 0.074 ; Table x^2 = 3.641
 df = 1 ; p = .05
 % obtained x^2 Table x^2 , ; Null hypothesis

It may, therefore, be maintained that drug use neither increases with joint family nor decreases with nuclear family.

ii) **Family composition** : The composition of family has also relationship with intra-family relationships and upbringing of children. In the case of our respondents, it was found that 87.2 per cent non-users, 87.3 per cent past-users and 88.0 per cent current users were living in families where both parents were alive ; where only mother was alive the percentages of non-users, past users and current users were 8.1, 7.7 and 6.3 respectively. While in the families where only father was alive, pas users and current users were 5.1 per cent and 5.7 per cent respectively compared to 4.7 per cent non-users.

TABLE 6.4COMPOSITION OF FAMILIES OF DRUG USERS AND NON-USERS

Composition of family	Non-users	Past-users	Current users	Total
1. Both parents alive	75 (87.2)	34 (87.2)	154 (88.0)	188 87.9
2. Only mother alive	7 (8.1)	3 (77.0)	11 (6.3)	14 (6.5)
3. Only father alive	4 (4.7)	2 (5.1)	10 (5.7)	12 (5.6)
TOTAL	N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 214 (100.0)

Comprising the family composition of non-users with that of ever-users, it was found that 87.9 per cent ever-users and 87.2 per cent non-users had both parents alive, 6.5 per cent ever-users and 8.1 per cent non-users had only their mothers alive while in the case of 5.6 per cent ever-users and 4.7 per cent non-users only their fathers were alive. The living parents or parent (mother or father) are supposed to be responsible for upbringing of children.

Statistically, obtained value of $\chi^2 = .8489$;
 Table value of $\chi^2 = 9.488$, $df = 4$, $p = .05$ enables
 us to confirm that null hypothesis that there is
 no relationship between joint/undivided family and
 drug use.

- iii) **Marital Status of Drug Users :** We have already
 analysed in Chapter 4 the association between
 marital status and drug use. Of the 300 drug users
 in the sample, 78.3 per cent were unmarried, 13.3
 per cent married, 6.0 per cent engaged and 2.4 per
 cent divorced, widowers or widows (See Table 6.5).

TABLE 6.5
MARITAL STATUS OF DRUG USERS

Marital status	Non- users %	Past- users %	Current- users %	Total of sample %
Unmarried	72.1	66.7	84.0	78.3
Married	18.6	15.4	10.3	13.3
Engaged	7.0	10.3	4.6	6.0
Divorced/Widow	2.3	7.7	1.1	2.4
GRAND TOTAL	N - 86 (100.0)	N - 39 (100.0)	N - 175 (100.0)	N - 300 (100.0)

The above data on the marital status indicates that drug users were more frequently single. This does not mean that they were not married because they used drugs. Most of the students in this modern era marry only after completing their education and settling in life. This data also cannot be used to point out that drug using habit of students will necessarily involve them in marital failures or inability in seeking marital partners, though it is very well known that once a person uses excessive or continuous drugs, his acceptibility as a marriage partner diminishes. This is specially so if his inability to play the expected social, economic, emotional and reciprocal roles required of spouse and parent is apparent. Most probably, the very low proportion of married, engaged and divorced/widowed respondents among the drug users is indicative of a higher sense of social responsibility in them compared to that among the unmarried ones.

d)

Parents-children Relationship

Analysis of the parents-children relationships helps in determining the role of family environment, particularly the parents' control

over their children and children's confidence in their parents. Assuming that one of the factors that affects intra-family relations is the family size, we assessed the drug user's families.

- i) **Family size** : Taking the nuclear and joint families of the drug users together, it was found that in 3.5 per cent cases, the size of drug users' family was three or less members, in 53.7 per cent cases 4 to 6 members and 32.7 per cent cases 7 or more members. (See Table 6.6)

TABLE 6.6

SIZE OF FAMILY OF DRUG USERS AND NON-USERS

S.No.	Family size	Non-users	Past users	Current users	Total
1.	3	12 (14.0)	4 (12.8)	24 (13.7)	41 (13.7)
2.	4 - 6	46 (53.5)	21 (53.8)	94 (53.7)	161 (53.7)
3.	7 - 9	23 (26.7)	10 (25.6)	44 (25.1)	77 (25.7)
4.	10 +	5 (4.8)	3 (7.7)	13 (7.4)	21 (7.0)

Note : Figures in parenthesis are percentages.

$$x^2 \text{ (chi)} = .3106 ; \text{ d.f. } = 6$$

$$x^2 6.05 = ; \text{ Table value } = 12.592$$

Does family size affect the drug usage ? The chi-square test did not indicate any relationship between the two variables.

TABLE 6.7

CORRELATION BETWEEN FAMILY SIZE AND DRUG USE

Family size	Non-users	Ever-users	Total
Small (3)	12	29	41
Moderate (4 - 6)	46	115	161
Large (6 +)	28	70	98
TOTAL	86	214	300

$$\begin{array}{lclclcl} \text{Obtained } x^2 & = & .0069 & ; & \text{Table } x^2 & = & 5.991 \\ \text{df} & = & 2 & ; & p & = & .05 \end{array}$$

On the basis of obtained x^2 value, we may hypothesize that family size (i.e. family being neither small nor large) has no association with drug use.

These figures showed that the families of drug users were not very large to create the problem of maintaining discipline by the parents over children. Out of 53.7 per cent families with 4 to 6 members, in 68 per cent families parents were living with their unmarried children, in 4.5 per cent parents with one or two married children without issues and unmarried children. Only in 0.4 per cent families are the married children had issues. In 33.7 per cent families with 7 or more members parents with their parents and siblings and unmarried children and married children (with their wives and issues) were found living.

- ii) **Upbringing of Children** : in 87.9 per cent families of drug users and in 88.4 per cent families of non-users children were brought up by both parents (who were alive), while the respective proportions for ever-users' and non-users' families where only mothers were alive were 7.0 per cent and 7.0 per cent and where only fathers were alive were 5.1 per cent and 4.6 per cent. In no case the children were brought up by some other kin (See Table 6.8)

TABLE 6.8UPBRINGING OF DRUG USERS AND NON-USERS

rought up	Non-	Past-	Current users	Total
Both parents	76 (88.4)	34 (87.2)	154 (88.0)	264 (88.0)
Mother alone	6 (7.0)	3 (7.7)	12 (6.9)	21 (7.0)
Father alone	4 (4.6)	2 (5.10)	9 (5.1)	15 (5.0)
TOTAL	N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)

Since all the drug users (and non-users) were brought up by their parents (both or single and by no other kin) and 75.2 per cent ever-users lived in nuclear families and 82.7 per cent of ever-users lived in not so large-sized families (upto 6 members), the **interpersonal relationship** in these families could be analysed to understand family relationship patterns.

e) Relationship Patterns

Out of 214 drug users in 87.9 per cent cases both the parents of drug users were alive. Of these in 85.1 per cent cases the relations between drug users' father and mother were harmonious, in 10.6 per cent cases discordant and in 4.3 per cent cases indifferent (See Table 6.8*). Since in very large number of cases, the conjugal role relationship between users' parents was as joint as possible, we could expect them carrying out parental activities together, with a minimum of task differentiation and separation of interests.

As regards the relations of drug users with their parents, in 84.1 per cent cases relations between drug users and their parents were harmonious, in 10.7 per cent cases discordant and in 5.1 per cent cases indifferent. Similarly, so far as the relations of drug users' with their siblings are concerned, in 25.2 per cent cases (54) the users were either the only children (29) or their siblings were infants (25). Of the remaining 160 cases, 84.3 per cent drug users had harmonious relations with their siblings, 9.4 per cent had discordant relations and 6.3 per cent had indifferent relations (See Table 6.8). Children having different types of relations with parents and/or siblings come to see world differently. They develop

different conceptions of social reality, different aspirations, hopes and fears and different conceptions of the desirable.

On the basis of the above figures, we could say that broadly speaking, in about 82 to 88 per cent cases, the families of drug users could be described as normal and family relationships as affectional and only in 12 to 15 per cent cases family relationships could be viewed as non-affectional.

The comparison of the families of male and drug users with those of the female drug users also showed that the proportion of affectional family relationships among the former was almost equal to that among the latter. When families of the users compared with those of the non-users, it was found that the degree of fragmentation (or disintegration) in users's families was no more than in non-users's families.

Thus in about 8 to 9 out of every 10 cases, the hosteler (male or female) was not exposed to a highly emotionalised atmosphere of discontent and discard, yet he

1.	2.	3.	4.	5	6.	7.
3	<u>BETWEEN SIBLINGS</u>					
i)	Harmonious	* 54 (83.1)	* 24 (82.8)	111 (84.7)	*135 (84.3)	*189 (84.0)
ii)	Discordant	7 (10.7)	3 (10.3)	12 (9.2)	15 (9.4)	22 (9.8)
iii)	Indifferent	4 (6.2)	2 (5.9)	8 (6.1)	10 (6.3)	14 (6.2)
iv)	Respondent had no Sibling or had infant Sibling	21 (24.4)	10 (25.6)	44 (25.1)	54 (25.2)	75 (25.0)
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 214 (100.0)	N = 300 (100.0)

Note : Since 25% of respondents were either only children or had only infant siblings, relations between siblings are calculated on the basis of 75% respondents.

RELATIONS AMONG FAMILY MEMBERS OF NON-USERS AND USERS

S.No.	Relations	Non- users 3.	Past- users 4.	Current- users 5.	Ever- users (4+5) 6.	Total 7-
1.	2.					
1.	<u>BETWEEN SELF AND PARENTS</u>					
i)	Harmonious	73 (84.9)	33* (84.6)	147 (84.0)	180 (84.1)	253 (84.3)
ii)	Discordant	9 (10.5)	4 (10.2)	19 (10.0)	23 (10.7)	32 (10.7)
iii)	Indifferent	4 (4.6)	2 (5.1)	9 (5.1)	11 (5.2)	15 (5.0)
	TOTAL	N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 214 (100.0)	N = 300 (100.0)
2.	<u>BETWEEN FATHER AND MOTHER</u>					
i)	Harmonious	65 (85.5)	29 (85.3)	131 (85.1)	160 (85.1)	225 (85.2)
ii)	Discordant	8 (10.5)	3 (8.8)	17 (11.0)	20 (10.6)	28 (10.6)
iii)	Indifferent	3 (3.9)	2 (5.9)	6 (3.9)	8 (4.3)	11 (4.2)
	TOTAL	N = 76	N = 34	N = 154	N = 188	N = 264 (100.0)

he used drugs. As such "non-affectional family" relationships can be described as an important reason for drug use only in one to two out of 10 cases of drug users. The figures leading to this finding are displayed in Table 6.9.

Since in more than 8 out of 10 cases (above 80 per cent), the relationship between users and their parents, between parents and between siblings were harmonious, we could expect that there was discipline in the families and their interpersonal relationships were not marred by dissensions and discord. The chi-square test also did not point out any association between drug use and discordant relations within the family.

If the intra-family relations are not the cause of consuming drugs, is it the nature of (i) parental control, (ii) parental role performance, (iii) standard of behaviour of family members and (iv) sharing of confidence between parents and children that has any association with the incidence of drug use ? Let us evaluate these variables. We propose to discuss them as some other attributes of affectional family. They add to normal functioning of the family by increasing its cohesiveness and integration through lessening of tensions and cementing bonds of cordiality and harmony.

i)

Family Control

Out of 214 (past and current) drug users, in 12.6 per cent cases, parent control over their children was found to be very strict, in 41.1 per cent cases moderate and in 46.3 per cent cases very lenient. The moderation and leniency in parental control did not mean that parents were not concerned about any activity having adverse effects on their studies or character. Parents in 34.4 per cent cases admonished their wards for any suspected/alleged serious deviance while in 64.6 per cent cases parents/guardians ignored their wards' alleged lapses. In all, only 37 cases of serious deviance lapses. In all, only 37 cases of serious deviance (such as skipping classes, avoiding participation in extra-curricular/co-curricular activities, being formally reprimanded by hostel authorities for misbehaviour etc.) were reported relating to 175 current drug users. (See Table 6.10).

TABLE 6.10NATURE OF PARENTAL CONTROL OVER USERS AND NON-USERS

Nature of control	Non-users	Past users	Current users	Total
1. Very strict	12 (14.0)	5 (12.8)	22 (12.6)	39 (13.0)
2. Moderate	34 (39.5)	16 (41.0)	72 (41.1)	122 (40.7)
3. Lenient	40 (46.5)	18 (46.2)	81 (46.3)	139 (46.3)
TOTAL	N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.00)

Comprising parents' control over drug users with the control over non-users, it was found that among the 86 non-users, in 13.9 per cent cases parental control was strict, in 39.5 per cent cases moderate and in 4.65 per cent cases lenient. It is clear from these figures that the nature of parental control over the users and the non-users is not much different from each other. This shows that leniency or strictness in parental control is not an important factor leading to drug abuse. This hypothesis can be tested statistically through figures in Table 6.11.

TABLE 6.11CORRELATION BETWEEN PARENTAL CONTROL & DRUG USE

	Non- users	Ever- users	Total
Strict	12	27	39
Moderate	34	88	122
Lenient	40	99	139
TOTAL	86	214	300

Obtained x^2 = .1229 ; Table x^2 = 5.991
 df = 2 p = .05

The obtained x^2 value indicates that there is no association between strict/lenient parental control and the drug use. Therefore, our null hypothesis is not justified.

ii) Birth Order

It is generally believed that the birth order of children influences family (or parental) control over the children's behaviour. Let us now analyse our data to test the truth or falsehood of this belief. Comparing the proportion of drug use in terms of the birth order of respondents, it was

found that 9.3 per cent drug users in the sample were the youngest children of the family, 29.4 per cent were the eldest children, 51.4 per cent were the middle children and 9.8 per cent were the only children of their parents. These figures show that the percentage of drug users was the lowest among the youngest children followed by the only children of their parents.

Since 51.4 per cent of the drug users were middle born children in comparison to 53.5 per cent among the non-users, we could say that being the eldest or the youngest or the only child of the parents did not make the respondents so pampered as to be free of parental control to the extent of indulging in deviant behaviour of drug use (See Table 6.12).

TABLE 6.12

BIRTH ORDER OF DRUG USERS AND NON-USERS

Birth order	Non-users	Past users	Current users	Total
1. Eldest child	21 (24.4)	12 (32.80)	51 (29.1)	84 (28.0)
2. Youngest child	10 (11.6)	4 (10.3)	16 (9.1)	30 (10.0)
3. Middle child	46 (53.5)	20 (51.3)	90 (51.4)	156 (52.0)

TABLE 6.12 CONTD.

Birth order	Non-users	Past users	Current users	Total
4. Only child	9 (10.5)	3 (7.7)	15 (10.3)	30 (10.0)
TOTAL	N = 86 (100.00	N = 39 (100.0)	N = 175 (00.0)	N = 300 (100.0)

$$\begin{array}{lclcl}
 x^2 & = & 1.5636 & ; & T.V. & = & 12.592 \\
 df & = & 6 & ; & p & = & .05
 \end{array}$$

(Ever-users : Eldest 29.4 per cent, youngest 9.3 per cent, middle 51.4 per cent, and only child 9.8 per cent).

Let us apply for chi-square test and examine the hypothesis that birth order does not affect the drug use.

TABLE 6.13

**RELATION BETWEEN BIRTH ORDER AND DRUG
USE BY DRUG USERS IN THE SAMPLE**

Birth order	Male	Female	Total
1. Eldest child	47	16	63
2. Youngest child	15	5	20
3. Middle child	82	28	110
4. Only child	16	5	21
TOTAL	N = 160	N = 54	N = 214

Calculated χ^2	=	.0294
Tabulated χ^2	=	7.815
df	=	3
p	=	.05

Our null hypothesis is negatived.

i) Parents' Awareness of Children using Drugs

It is an important ingredient in familiar control. Did the parents know that their children were taking drugs and did they attempt to prevent them from use ? In our sample 45.10 per cent of current users (79) confessed that their parents had such knowledge, while 54.9 per cent said that their parents were not aware of it. In the former case in 16.4 per cent cases children were prevented by their parents from taking drugs while in 49.4 per cent cases there was no such effort and in 34.2 per cent cases respondents kept mum (N.R.) when questioned about their parents' action, if any, consequent upon the knowledge of their children's drug use (See Table 6.14)

TABLE 6.14

PARENTS' AWARENESS OF CHILDREN'S
DRUG USE AND CONSEQUENT ACTION*

Awareness/Action	Past users	Current users	Ever- users
1. Not aware	71 (53.8)	96 (54.9)	117 954.7)
2. Aware	18 (46.2)	79 (45.1)	97 (45.3)
TOTAL	N = 89 (100.0)	N = 175 (100.0)	N = 214 (100.0)
1. Prevented drug use	10 (55.6)	13 (16.4)	23 (23.7)
2. Made not effort	6 (33.3)	39 (49.6)	45 (46.4)
3. No response	2 (11.1)	27 (34.2)	29 (29.9)
TOTAL	N = 18 (100.0)	N = 79 (100.0)	N = 97 (100.0)

Consequent action from those parents only who were aware of their children's drug use.

It is difficult to say why in 83.6 per cent cases (of current users) parents did not try to take any measures to prevent the children from indulging in drug-deviant behaviour. Could it be because parents themselves smoked cigarettes, drank alcohol or used some other drugs.

ii)

Parental Roles

The roles performed by parents included parents' interest in the development and career of their children and parental obligations toward the children. In our sample, it was found that parents tried to impose proper discipline over their children, though the latter were not expected to observe a rigid schedule during holidays and vacations when hostellers visited their homes. The atmosphere in the homes was conducive to smooth interaction between parents, siblings and other kinds and the children (hostellers). It was in no way stifling or inhibiting. There was room for laughter, jokes, entertainment, company and adventure. In 94.9 per cent cases, parents took keen interest (always/sometimes) in drug users' studies, and in 65 to 94 per cent cases, they took keen interest in their (children/wards) nature of friendship, leisure activities and future career. When respondents revealed that their parents always showed very keen interest in their studies, future career and nature of friendship. Only in 3.00 per cent cases, the parents were described as indifferent (See Table 6.15).

TABLE 6.15PARENTS' INTEREST IN CHILDREN

Took interest in children 1.	Non- users 2.	Past users 3.	Current users 4.	Total (3+4) 5.
1. Studies	77 (89.5)	35 (89.7)	168 (93.0)	203 (94.9)
2. Nature of friend ship	70 (81.4)	28 (71.8)	112 (64.0)	140 (65.4)
3. Leisure activities	68 (79.1)	31 (79.5)	129 (73.7)	160 (74.8)
4. Future career	80 (93.0)	37 (94.9)	163 (93.10)	200 (93.4)
TOTAL	N = 86 (100.00)	N = 39 (100.0)	N = 175 (100.0)	N = 214 (100.0)

* Total exceeds 100 per cent due to multiple responses.

TABLE 6.16PARENTS' INTEREST IN CHILDREN'S CARRER

Nature of interest	Non- users	Past- users	Current users	Total
Very much	93.0	95.0	93.1	93.4
Satisfactory nature	4.0	3.0	5.0	4.0
Indifferent	3.0	2.0	1.9	2.6
TOTAL	100.0	100.0	100.0	100.0

Similarly, in 96.5 per cent cases drug users said that their parents frequently discussed problems with them (61.2 per cent) and advised them (67.8 per cent) and encouraged them (75.2 per cent). (Table 6.17).

However, 90.3 per cent current drug users said they were never taken into confidence by their parents (See Table 6.18). But then 88.4 per cent non-users and 89.8 per cent past users also faced the similar problem.

TABLE 6.17

DRUG USE AND PARENTS' PROBLEM
DISCUSSION, ADVICE AND ENCOURAGEMENT TO CHILDREN

Issue	Non users	Past users	Current users	Total
1. <u>DISCUSSING PROBLEMS</u>				
i) Never	4.6	5.1	6.2	17 (5.7)
ii) Seldom	9.3	10.2	9.7	28 (9.3)
iii) Occassionally	19.8	20.5	20.0	60 (20.00)
iv) Frequently	62.8	61.6	60.7	185 (61.7)
v) N.R.	3.5	2.6	3.4	10 (3.3)

TABLE 6.17 CONTD.

Issue		Non- users	Past- users	Current- users	Total
2. <u>ADVICE</u>					
i)	Never	2.3	2.6	2.3	⁷ (2.3)
ii)	Seldom	7.0	5.1	8.6	²³ (7.7)
iii)	Occasionally	18.6	17.9	18.9	⁵⁶ (18.7)
iv)	Frequently	68.6	71.8	66.8	²⁰⁴ (68.0)
v)	N.R.	3.5	2.6	3.4	¹⁰ (3.3)
3. <u>ENCOURAGEMENT</u>					
i)	Never	2.3	2.6	2.3	⁷ (2.3)
ii)	Seldom	5.8	5.2	5.1	¹⁶ (5.3)
iii)	Occasionally	14.0	15.4	14.9	⁴⁴ (14.7)
iv)	Frequently	74.4	74.4	75.4	²²⁵ (75.0)
v)	N.R.	3.5	2.6	2.3	⁸ (2.7)
TOTAL		N = 86	N = 39	N = 175	N = 300
		(100.0)	(100.0)	(100.0)	(100.0)

TABLE 6.18DRUG USE AND PARENTS TAKING
THEIR CHILDREN INTO CONFIDENCE

level of taking into confidence	Non- users	Past- users	Current users	Total
Never	88.4	89.8	90.3	²⁶⁹ (89.7)
Sometimes	2.3	2.6	2.3	⁷ (2.3)
Always	5.8	5.2	5.1	¹⁶ (5.3)
N.R.	3.5	2.6	2.3	⁸ (2.7)
TOTAL	N = 86	N = 39	N = 175	N = 300
	(100.00	(100.0)	(100.0)	(100.0)

TABLE 6.19DRUG USE AND PARENTS
SNUBBING/BEATING CHILDREN

Parents' behavi- our	Non- users	Past- users	Current users	Total
1. <u>SNUBBING</u>				
i) Never	77.9	77.0	77.7	(233) 77.7
ii) Seldom	14.0	15.4	14.9	(44) 14.7
iii) Occasionally	5.8	5.2	5.1	(16) 5.3
iv) Frequently	2.3	2.6	2.3	(7) 2.3

TABLE 6.19 CONTD.

parents' behaviour	Non- users	Past- users	Current users	Total
2. <u>BEATING</u>				
i) Never	82.6	82.7	80.7	(245) 81.7
ii) Seldom	9.3	10.2	9.7	(28) 9.3
iii) Occasionally	4.6	5.1	6.2	(17) 5.7
iv) Frequently	3.5	2.6	3.4	(10) 3.3
TOTAL	N = 86	N = 39	N = 175	N = 300
	(100.0)	(100.0)	(100.0)	(100.0)

Only in a very small number of cases the drug users' parents frequently snubbed or beat their children (see Table 6.18) or never discussed problems with them (5.6 per cent) or never advised (2.5 per cent) or encouraged (2.5 per cent) them. In these cases **only** it can be said that since parents had no real love or affection or concern for their children, the latter felt so neglected and ignored that they got mixed up with dubious company and stepped into a life of deviant drug behaviour, partly to overcome their complexes and emotional deprivations.

The statistical test also indicates that significant relationship exists between drug abuse and (a) parents' interest in children's career, (b) giving encouragement to children ; and (c) taking children into confidence.

TABLE 6.20

CORRELATION BETWEEN PARENTS'
INTEREST IN CHILDREN'S CAREER AND DRUG USE

Parents' Interest	Non-users	Ever-users	Total
Very much	80	201	281
Normal	4	9	13
Indifferent	2	4	6
TOTAL	86	214	300

Obtained x^2 = .0984 ; Table x^2 = 5.991
 df = 2 ; p = 0.05

H_0 (There is no association between parents' interest in children and drug use) = disproved.

TABLE 6.21

CORRELATION BETWEEN PARENTS'
ENCOURAGEMENT TO CHILDREN & DRUG USE

	Non- users	Ever- users	Total
Never	3	11	14
Seldom	10	43	53
Frequent	73	160	233
TOTAL	86	214	300

Obtained $\chi^2 = 3.650$; Table $\chi^2 = 5.991$
 $df = 2$; $p = 0.05$

H_0 (There is no association between parents' encouragement to children and drug use) = disproved.

TABLE 6.22

CORRELATION BETWEEN PARENTS'
TAKING CHILDREN INTO CONFIDENCE & DRUG USE

	Non- users	Ever- users	Total
Never	76	193	269
Sometimes	5	11	16
Always	5	10	15
TOTAL	86	214	300

Obtained χ^2 = 0.2352 ; Table χ^2 = 5.991
 df. = 2 ; p = 0.05

H_0 (There is no association between parents' taking children into confidence and drug use) = disproved.

Keeping in mind the fact that in a very large number of cases (about 93 per cent), the children felt satisfied with their families, we reject the theoretical explanation that the youth turn to drugs either to cope with family stress or to face estrangement from family because of lack of parental affection and love for them.

The statistical analyse of these data shows that in large number of cases, drug users had conscientious parents who were conscious of their parental obligations toward their children. Our findings here converge with those of Dr. Ahuja in regard to parental roles' performance in his surveys (1976 and 1986) of drug abuse among Jaipur students. He said, "We cannot say that drug using students in our sample had no real love or companionship or proper guidance, supervision and concern from their parents. Nor could we say that

parents were so busy in their own worlds that children felt neglected and ignored, got mixed up with rather dubious company and stepped into a life of deviant drug behaviour - partly to overcome their various complexes and emotional deprivations."³

Our analysis also shows that non-user hosterlers in our sample (86 cases) had about 7 to 10 per cent defective family relationships or defective control compared to 5 to 8 per cent defective family cohesion in drug user population (214 cases). It could, therefore, be maintained that environment in drug users' homes in terms of normal parental control was not an important factor in drug use behaviour.

iii) Confidence Sharing between Children and Parents

Our hypothesis that non-affectional family relationships have an important bearing on drug-use behaviour was disproved. This position is further reinforced if we examine confidence sharing between parents and children. If the

3. R. Ahuja, *op. cit.* p. 89.

children have faith and trust in their parents to provide them necessary emotional security and guidance when they are faced with any problems, vexing or not so vexing, it makes family relationships more enduring and harmonious. The normal cooperation and sympathy extended to children by parents instils in them a sense of frankness and they freely confide in their parents about their (children's) troubles and difficulties. Parents also often share their confidence with their children and repose faith in them. This mutual sharing of confidence and faith between parents and children helps strong reinforcement of family bonds.

In our sample, a very large proportion of both drug users (87.8 per cent) and non-users (90.6 per cent) conformed to the abovesaid behaviour pattern, i.e. they belonged to affectional family type.

iv) Standard of Family Members' Behaviour

In the previous section we have analysed the relationship between drug use and youths' alienation or estrangement from their families

and found that no such relationship exists. Now, we turn to examine the second altern-active theoretical explanation according to which family helps to shape the adolescent drug use through providing role models.

As regards parents' habits, in 77.7 per cent cases of current drug users, the parents had no habit (of smoking/drinking/drug-taking) at all ; in 21.2 per cent cases they had some habit, and in 1.1 per cent cases they did not respond to this question. of those 37 cases which had same habit, in 43.3 per cent cases they only smoked cigarettes (bidies or used gutakas), in 27.0 per cent cases they only took alcohol, in 8.1 per cent cases they smoked and took alcohol, in 10.8 per cent cases, alongwith taking drugs, they consumed tobacco and alcohol also. (See Table 6.23).

TABLE 6.23

DRUG TAKING HABIT OF PARENTS
OF DRUG USERS AND NON-USERS

S.no.	Habit	Non- users	Past- users	Current- users	Total
1.	No habit	67 (77.9)	29 (74.4)	136 (77.70)	232 (77.3)
2.	Only smoking	6 (7.0	4 (10.2)	16 (9.10	26 (8.70

TABLE 6.23 CONTD.

S.No.	Habit	Non- users	Past- users	Current- users	Total
3.	Only drinking	5 (5.8)	2 (5.1)	10 (5.7)	17 (5.7)
4.	Only drugs	2 (2.4)	-	4 (2.2)	6 (8.0)
5.	Smoking and drinking	3 (3.5)	1 (2.6)	3 (1.7)	7 (2.3)
6.	Drinking and Drug taking	1 (1.2)	1 (2.6)	2 (1.1)	2 (1.3)
7.	Smoking and Drug taking	-	-	2 (1.1)	2 (0.7)
8.	Smoking, Drinking and Drug taking	-	-	-	-
9.	No Response	2 (2.4)	2 (5.1)	2 (1.1)	6 (2.0)
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)

In comparison to the drug users, amongst the non-users 77.9 per cent parents had no habit of any kind, 19.7 per cent had some habit (of smoking/drinking/drug taking) and 2.4 per cent did not respond. Of those 17 parents of non-users who had some habit, 35.3 per cent only smoked cigarettes, 29.4 per cent only alcohol, 2.40 per cent took only drugs and in 5.9 per cent cases, along with taking drugs, they drank alcohol also

The comparison of drug users' and non-users' parents' drug-taking habit show that non-users' parents used less drugs (only smoking or only drinking, smoking and drug taking) and more drugs (only drug and smoking and drinking together) compared to the users' parents.

To analyse the drug taking habit of the respondents' siblings and other family relations we first distributed both the siblings and other relations among the non-users, past users and current users, and then analysed their corresponding drug use habit for different drugs (intoxicating substances).

TABLE 6.24

DISTRIBUTION OF DRUG-USING
AND NON-USING SIBLINGS AND OTHER RELATIONS*

Relations	RESPONDENTS			Total
	Non-users	Past-users	Current users	
1. <u>SIBLINGS</u>				
i) Drug using	4 (4.7)	3 (7.7)	33 (18.9)	40 (13.3)
ii) Non-using	78 (90.6)	24 (61.5)	18 (10.3)	120 (40.0)

TABLE 6.24

Relations	Non- users	Past- users	Current- users	Total
2. <u>OTHERS</u>				
i) Drug-using	8 (9.3)	10 (25.6)	59 (30.7)	77 (25.7)
ii) Non-using	80 (93.0)	25 (64.1)	73 (41.7)	178 (59.3)
TOTAL	N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)

$$x^2 \text{ (chi)} = 147.364 \quad ; \quad \text{Table } x^2 = 12.592$$

$$df = 6$$

* Drug taking includes only painkillers and tranquilisers use.

** Totals exceed 100 per cent due to multiple responses.

Our respondents told that they had only 160 adult siblings and 255 other relations (besides siblings) who could be considered relevant for drug-use or non-use. Of 160 siblings 40 (25 per cent) were found drug users and 120 (75 per cent) non-users. Of 255 respondents, other relations 77 (30.2 per cent) were drug users and 178 (69.8 per cent) non-users.

Let us now analyse the drug-taking habits of respondents' sublings and other relations.

TABLE 6.25

DRUG-TAKING HABITS OF SIBLINGS AND OTHER RELATIONS*

Habit	EVER USERS				Ever-users themselves**	
	Siblings		Other Relations			
1. Only smoking	10	(25.0)	19	(24.6)	78	(36.4)
2. Only drinking	6	(15.0)	11	(14.3)	60	(28.0)
3. Only drugs	5	(12.3)	10	(13.0)	22	(10.3)
4. Smoking and Drinking	6	(15.0)	13	(16.9)	50	(23.3)
5. Drinking and Drug-taking	4	(10.0)	7	(9.1)	48	(22.4)
6. Smoking and Drug-taking*	3	(7.5)	6	(7.8)	40	(18.7)
7. Smoking, Drinking and Drug-taking*	3	(7.5)	5	(6.5)	30	(14.0)
8. No Response	3	(7.5)	6	(7.8)	-	
TOTAL	40	(100.0)	77	(100.0)	214	(100.0)

* Drug taking includes only painkillers and Tranquillisers use.

** Totals exceed 100 per cent due to multiple responses.

On a close look at the Table 6.25 figures, it becomes clear that the habits of ever-users' siblings and other relations represent almost

similar pattern in their drug-using behaviour. Smoking and drinking were the most favourite pastimes. Only drug use came last. In descending order, smoking and drinking came third followed by drinking alongwith drug taking, smoking alongwith drug-taking and smoking and drinking alongwith drug-taking. Ever-users' siblings and other relations smoked in 25.0 per cent and 24.6 per cent cases respectively. While they drank in 15.0 per cent and 14.3 per cent cases respectively. Corresponding figures for taking only drugs were 12.3 per cent and 13 per cent. The use of different drugs in combination with smoking and/or drinking was in gradually decreasing proportions.

The Indian Society on Tobacco and Health has recently made some disturbing disclosures in this respect. 70 per cent children of smokers take to smoking as compared to only 10 per cent of children of non-smokers and 30 per cent smokers take to drugs, as against 3 per cent of non-smokers, and die a slow painful death⁴.

When smoking, drinking and other drug taking habits of siblings and other relations of the families of ever-users with those of the

ever-users themselves were compared, it was quite revealing. In families where more respondents, siblings and other relations were found involved in drug taking behaviour there was higher incidence of drug use among respondents themselves. Thus, our hypothesis, that family members by their standard of behaviour influence positively and behaviour of the children in respect of both drug use of non-user, is proved. In other words, there is greater chance of children being involved with drug-taking behaviour where there is a drug problem in their families compared to those children whose families are free from this problem. The family does help to shape the adolescents drug use through providing role models.

In summary, the picture of family factors in drug use is not at all provocative. Though the family can be said to assume an important role in helping to create an atmosphere in which drug use may or may not occur, our study did not indicate a significant number of drug users who had taken to drugs to face stress or anxiety generated by their

families. But many youths had taken to drugs due to the fact that their parents, siblings and other relations were using drugs. In fact, there is no serious drug abuse problem in our subjects but since it is gradually assuming more serious proportions, the menace needs to be curbed without delay.

THE ROLE OF PEERS

The "wrong friends" or drug user peer group hypothesis is probably an old explanation of drug use. It is a truism that most smoking, drinking and drug taking activities occur in social groups and there is little solitary drug use. (There are exceptions also. Many persons are solitary drinkers, smokers and drug-takers too). Sociologists have recently focussed less on drug-taking as the problem and paid greater attention to the social environment that breeds it. More research is directed to the social patterns of drug use (as related to peer groups, subcultures, and adverse or beneficial adaptive effects on individual, group or community functioning).⁵ Peer groups are said to be the most important single source of drug information for users.

5. Paul H. Blachy (ed.), **Drug Abuse : Data and Debate**, Charles C. Illinois, USA, 1970, p. 300.

for users. Drugs and alcohol are usually obtained from friends and drug users tend to have more friends and associates who are also drug users.

Adolescence and youth are the periods of stress and susceptibility. Peer group pressure is probably more influential at this time than at any other. The college student, who has newly separated from his home and has yet insufficiently developed internal and social restraints, is more likely to take to impulsive and irresponsible behaviour. Youth age is characterised by active drives which can be highly anxiety-producing. It is this situation where many of the drugs act seductively. These drugs seem particularly seductive to young people because they may neutralise the said drives temporarily and provide relief from their pressure. They also 'promise' to provide answers to the various questions that trouble many young people.

Does our study also indicate that many youth had become drug users because they associated with drug using friends ? Our investigation aimed at finding out : (1) extent of friends' influence in starting drugs, (2) incidence of drug use among drug users' friends, and (3) what type of drugs were consumed by drug-users' friends.

INCIDENCE OF DRUG USE AMONG FRIENDS

Of the 175 current drug users studied, 76.0 per cent said that their friends neither smoked nor took alcohol or illicit drugs, while 24.0 per cent said that their friends had some habit. In those 42 cases in which friends had some habit, 17.7 per cent only smoked and 4.6 per cent only took alcohol. Only 0.6 per cent friends of drug users were in the habit of taking some illicit drugs. (See Table 6.26).

In comparison to 24.0 per cent current drug users having friends who smoked, took alcohol or consumed illicit drugs or used both tobacco and alcohol, among the non-users 19.8 per cent had friends who smoked or took alcohol, or used both tobacco and alcohol. No friend of non-users used illicit drugs. Among the past-users, 25.6 per cent had friends who smoked or used alcohol.

TABLE 6.26

DRUG USING HABIT OF DRUG USERS' FRIENDS

S.No.	Nature of habit	Non-users	Past users	Current users	Total
1.	No habit	69 (80.2)	29 (74.4)	133 (76.0)	231 (77.0)
2.	only smoking	8 (9.30	7 (17.9)	31 (17.7)	46 (15.3)

TABLE 6.26 CONTD.

S.No.	Nature of habit	Non-users	Past-users	Current users	Total
3..	Only drinking	5 (5.8)	2 (5.1)	8 (4.6)	15 (5.0)
4.	Only drugs	-	-	1 (0.6)	1 (0.3)
5.	Smo,ing and Drinking	4 (4.7)	1 (2.6)	2 (1.1)	7 (2.3)
6.	Smoking and Drug-taking	-	-	-	-
7.	Drinking and drug taking	-	-	-	-
8.	Smoking, drinking and drug-taking	-	-	-	-
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)

Does this fact that 2.4 out of every 10 drug users had friends who smoked or drank alcohol or used illicit drugs and 2.0 out of every 10 non-users had friends who earlier smoked or drank alcohol indicate any association between drug use by hostelers and their having friends who had "bad habit of using drugs" ?

Obtained x^2 = 3.8486 Table x^2 = 12.592
 df = 6 p = 0.05

Null hypothesis not justified.

Testing the null hypothesis that smoking/drinking/drug taking by friends does not affect the incidence of drug use among hostel inmates, it was found that the hypothesis was nullified.

TABLE 6.27

DRUG TAKING HABIT OF THE RESPONDENTS' FRIENDS

	Habit	Non-users	Current-users	Total
1.	Taking alcohol/ smoking cigarettes using drugs	17 (19.8)	42 (24.0)	59 (22.60)
2.	Not taking alcohol/ smoking cigarettes using drugs	69 (60.2)	133 (76.0)	202 (77.4)
<hr/>				
	TOTAL	N = 86 (100.0)	N = 175 (100.0)	N = 261 (100.00)

It could, therefore, be held that the use of drugs was higher among those hostel inmates whose friends smoked/drank and/or took drugs.

The friends' influence on drug users can also be seen by the fact that 37.4 per cent respondents confessed that they were prompted by their friends to start taking drugs. (See Table 6.28).

WHO PROMPTED DRUG TAKING TO DRUG-USERS

S.No.	Substance	Self Curiosity	Physician	Parents	Siblings & Relatives	Friends	Place Media	Total
1.	Alcohol	32 (41.0)	2 (2.6)	6 (7.7)	-	25 (32.1)	13 (16.7)	78 (36.4) 100.0
2.	Tobacco	29 (48.3)	-	3 (5.0)	-	19 (31.7)	9 (15.0)	60 (28.0) 100.0
3.	Amphetamines	1 (16.7)	3 (50.0)	-	-	2 (33.3)	-	6 (12.8) 100.0
4.	Barbiturates	-	2 (100.0)	-	-	-	-	3 (0.9) 100.0
5.	Cannabis	2 (16.7)	-	-	-	8 (66.7)	2 (16.7)	12 (5.6) 100.0
6.	Heroin	-	-	-	-	1 (100.0)	1	1 (0.5) 100.0
7.	L.S.D.	-	-	-	-	1 (100.0)	-	1 (0.5) 100.0
8.	Opium	-	-	-	-	-	-	-
9.	Peth/Morphine	-	-	1	1	1	1	1
10.	Painkillers	7 (18.4)	8 (21.1)	-	2 (5.3)	18 (47.4)	3 (7.9)	38 (17.8) 100.0
11.	Tranquilisers	6 (37.5)	4 (25.0)	-	-	6 (37.5)	-	16 (7.5) 100.0

All Drugs together N = 77 N = 19 N = 9 N = 2 N = 80 N = 27 N = 214
36.0 8.9 4.2 0.9 37.4 12.7 100.0

Though on the whole only 37.4 per cent drug users had started taking drugs on their 'frienas' prompting, but taking each substance separately, it was found that 32 to 100 per cent alconol, amphetamines cannabis, painkillers and tranquilisers, tobacco users had started the substance in their frienas' company, while one hosteler (male) each who was taking L.S.D. or heroin had started taking it on his friend's prompting. This suggests the important role of friends in initiating the hostelers to drug use.

To conclude, the drug users have a stronger identification with drug users than with non-users. They seek out as friends people who feel and behave the way they do, and may choose friends who have an aberrant orientation. It can also be held that the drug users may use drugs not only for whatever pharmacological effects they may have (in reducing tension, producing an enjoyable high, relaxding bodily stiffness and so on), but also as a means of signalling membership in a meaningful primary (friends') group. Thus, the 'glamour' of drug culture is radicated largely through age peer group.

But our investigation is still not complete. We must examine the social contexts which function as environments or miliree in which the drug-directed behaviour is acquired. The following chapter focusses on this aspect.

CHAPTER - VII

KNOWLEDGE OF DRUGS AND PERCEPTUAL IMAGES

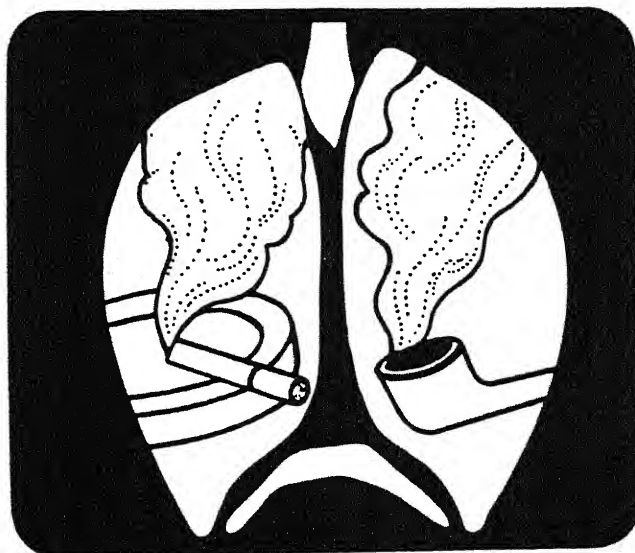
MARIJUANA



SEDATIVE HYPNOTICS



SMOKING AND HEALTH



CHAPTER - VII

KNOWLEDGE OF DRUGS AND THEIR PERCEPTUAL IMAGES

1. DRUG KNOWLEDGE

Dr. Ram Ahuja and other have indicated that at least five types of social contexts function as environments or learning paths (initiation and habit-forming tracks) in which drug-directed behaviour is acquired : knowledge of the drug, availability of the drug ; ability to administer/consume properly ; sanctions which define drug use as desirable and appropriate ; and social reinforces such as approval, recognition and prestige for experimentation (or use continuously) with drugs. Here they also point out to the fact that social re-inforcers constitute the sub-culture of the dominant culture prevailing in a particular society.

On a close reflection, we would like to disagree with this classification attempted by the above researchers. In our view, social sanctions, in their wider connotation, include social reinforcers also. Sanctions, as we understand, relate to the domain of ethics. They are defined as motives for obedience to any moral or religious

code (law). Sociologically speaking, sanction means the act of ratifying or giving authority. It is further obvious that only appropriate or socially desirable and approved customs and habits, manners and fashions (even small or significant deviations from them) etc. get different types of boosts and so are they, in part or whole and with different shades and degrees of conformity and non-conformity or even their mid-positions, of manifold and intricately interwired variations, get crystalised (not necessarily in a permanent or lasting mould), acquire acceptability/respectability, depending on their area of operation.

The social sanctions, including re-inforcers of a sub-culture, are different and smaller in number and function with lesser efficacy, as compared with those prevailing in a dominant culture. It would, therefore, suffice to identify only four types of social contexts instead of five ones.

However, this brief comment on the classification attempted by the learned authors of the "repeat survey" of "Drug Abuse Among University/College Students" in Jaipur city should not be construed to cast any reflection on the

very high quality, standard and sophistication of the research endeavour made by these authors. Though, we have not got the opportunity to scan the reports of repeat surveys relating to other metropolitan cities, prepared by eminent personalities belonging to other social sciences, besides sociology, we can vouchsafe for the splendid and painstaking efforts made by the two sociologists to make a thorough survey of drug abuse among college/university students of Jaipur metropolis.

Following the framework of study adopted by Dr. R. Ahuja and his associate, we sought to analyse our field data in respect of the said four social contexts. Let us, first encounter the first social context, i.e. knowledge of the drugs and see what does it signify in relation of our respondents.

Interestingly, our respondents were divided half - half with regard to the correct/precise knowledge of the drugs they were found using or non-using respectively. It was found that 58.1 per cent of our respondents did not have such knowledge ; only 42 per cent knew that college and university students who take drugs.

TABLE 7.1

**RESPONDENTS' KNOWLEDGE OF STUDENTS IN COLLEGES/
UNIVERSITIES TAKING HARD AND ADDICTIVE
DRUGS, INCLUDING ALCOHOL AND TOBACCO.**

Knowledge	Non- users	Past- users	Current users	Total (N)
No	54 (58.1)	20 (51.3)	104 (57.2)	174 (58.0)
Yes	36 (41.9)	19 (48.7)	70 (40.1)	125 (41.9)
N.R.	-	-	0.5 (2.7)	1 (0.3)
TOTAL	N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)

The table reveals correlational evidence that non-users possessed almost equal drug knowledge as the drug-users. The ratio of non-users having knowledge to users having knowledge was 1 : 1.

The fact that drug users indeed did have much knowledge about drugs usually taken by college/university students was supported by the fact that many users had wide knowledge about different drugs and were almost fully aware of drug terminology. The question on knowledge of

1. R. Ahuja, G.S. Kewalramani, **Drug Abuse among College students** (A survey report, 1987 (Mimeographt) Deptt. of Sociology, University of Rajasthan, Jaipur.
2. T. Green, **Sociology - An Analysis in modern context**, Impex Publications, New Delhi, 1991.

drug names was asked to test the hypothesis that the more knowledge about the drugs the individual have, the more likely they are to have taken drugs'. Since very large percentage of users named drugs quite correctly, our hypothesis is supported.

The cent percent drug users identified opiate drugs, 51 to 62 per cent sedatives, 7.9 per cent depressents, and 14.9 per cent hallucinogens. Even some modern drugs, especially highly toxic synthetics drugs, such as, brown-sugar, heroin and L.S.D. were known to most of the long staying hostellers. It was a shocking surprise to learn that even girl inmates/youngish looking male inmates boasted of their 'general knowledge' being quite high and wide ranging in respect of drug use explosion. Many of them confessed of having got this familiarity with 'drug culture' by seeing TV serials/shorts/advertisements, and 'sex-crime', drug scandals saturated films and by reading so-called modern western high-tech or sophisticated novels, and other fiction-thrillers.

Video parlours/theatres/discos/clubs screening clandestinely of course, youth leuring films, including blue films, and vending 'Gupta-Gyan' professedly to

provide purposeful sex-education have thrown and even widening dragnet around the susceptible youth and are, if we may be permitted to say, corrupting the psychic and moral fabric of our younger generation.

However, the above observations needs a cautious acceptance. The drug deluge has still not reached more than 10 to 20 per cent of our youth (in our case, hostel inmates).

TABLE 7.2

AWARENESS OF DRUG-USERS AND NON-USERS OF DRUG TERMINOLOGY

S.No.	Drug		Drug- users	Non- users	Past- users
1.	Amphetamine	110	46 (53.5)	15 (38.5)	51.4
2.	Barbitirates	132	54 (62.8)	24 (61.5)	61.7
3.	Cannabis	160	57 (66.3)	30 (76.9)	74.76
4.	Heroin	202	80 (93.2)	34 (87.2)	94.4
5.	L.S.D.	32	27 (31.4)	19 (48.7)	14.9
6.	Opium	214	74 (86.0)	33 (84.6)	100.0

TABLE 7.2 (CONTD.)

S.No.	Drug		Drug- users	Non- users	Past users
7.	Pathedrine/ Methedrine/ Morphine	17	12 (13.9)	11 (28.2)	7.9
8.	Pain-killers	204	82 (95.3)	35 (89.74)	95.3
9.	Tranquilisers	198	56 (65.1)	27 (69.23)	92.5
10.	Tobacco	214	86 (100.0)	39 (100.0)	100.0
11.	Alcohol	214	86 (100.0)	39 (100.0)	100.0
TOTAL		214	N = 86 (100.0)	N = 39 (100.0)	

2. MOTIVES IN DRUG-TAKING

What is to explain the cause of drug use ? While such question cannot be answered simply, yet some factors can be identified in the easy availability of drugs, the fad phenomenon associated with certain drugs, low cost of certain drugs, weakening of parental control over children, and to a certain extent tolerating attitude toward use of certain drugs like tobacco (cigarettes), pain-killers, tranquilizers, and so on.

Just as students differ, resident students who use drugs also differ, and it is a great mistake to get over-enthusiastic about any one explanatory idea. This becomes increasingly true as drug use spreads. There are, however, some general observations which may be useful.

All college/university students are in the stage of growth from adolescence to adulthood. This growth process involves both the unlearning of traditional modes of behaviour which were appropriate and rewarded in childhood and adolescence and the learning of upcoming or new modes in accordance with society's definition of the adult role. Becoming adult involves substituting independence for dependence, individual identity for assigned identity ; and meaningful social relationships with a variety of individuals outside the family circle for basic relationships inside the family. If still retained, cannot equip the young persons to face squarely the more complex world beyond the family ambit. It also involves development of meaningful sexual identity and appropriate masculine or feminine roles and a meaningful relationship to life and the meaning of life. The

3. Robert Buckhou (ed), **Toward Social Change**, Harper and Row Publishers, New York, 1971, p. 269.

attainment of maturity also involves the ability to postpone immediate gratifications in the interest of future/expected/projected long-range goals.³

1. Now, meaningful identity and a set of values to live cannot be bestowed on an individual like a mantle. The process of internalising them can sometimes or even often be painful. Becoming independent may sometimes involve rebellion. Developing an identity consistent with one's talents and abilities, hopes aspreations and dreams, requires hard work and experimentation which may be unsuccessful more often than it is successful. Developing mature, meaningful social relationships is difficult at best and the more so if independence and some degree of identity have not been achieved. The youth, by very definition, involves in maturity yet impatience to achive results. The gap between aspreation or dreams and hard realities usually leads to painful experiences. Tolerating the frustration caused by failure in achieving certain immediate goals becomes more difficult. Finding meaning in life may also be not easy. In such situations, taking drugs can be perceived as help in these difficult situations. But, such situations need not

necessarily drive/force a youth to drug abuse.

This explanation of drug use, however, is far those who take drugs "to escape from personal problems" or "to reduce anxiety" or to overcome tension and uncertainty caused in security. We may offer other explanations for those drug-users who take drugs for 'pleasure' or 'fun' or to induce to sleep , or facilitate social interaction, and so on.

2. Some drugs are socially acceptable and are generally available without difficulty. Therefore, some hostellers take these drugs in the company of like-minded peers for cultivation of social and personal relationships, for cherishing values which are not uncomfortable, or for a meaningful religious or spiritual sometimes even mysterious or tantric experience.
3. Another explanation of drug use can be found in the "indiscriminate medication". Belief in medication develops as a result of two factors :
(a) constantly hearing about the success of medical science (but ignoring the limitations and

side-effects of drugs), (c) deterioration of patient-doctor relationship because of doctors' tendency of prescribing too many drugs in the name of increased specialisation and prescribing many sedatives and tranquilizers unnecessarily. Relying more on medication than on the competence of the physicial, many persons medicate themselves excessively and indiscriminately.

4. An explanation may be found in the additude towards risks of drugs ideally, risk-taking involves rational decisions about the utility of a certain action but sometimes risk-taking is based on irrational thinking, hunch, impulse, mood or information that is inadequate and errouneous or even blatant lie and gross disinformations. A temporary feeling of invulnerability may induce individual to believe "it won't happen to me." Or, feeling of hopelessness or of being discriminated against may force him to believe that he has very little to lose. Thus, an adequate description of the risks involved in drug use may serve as an "effective deterrent" to some but have no effect or even the opposite effect on others.

5. There could be yet another explanation too. Many a young people finds such "hypocrisy" in the society that they find it useless to live according to socially accepted basic beliefs. They find this world full of aggression, discrimination, inequality, injustice, exploitation, poverty, misery, jealousy, hatred, selfishness, and fear, etc. They find this society as "achievement-oriented" society which measures success and prestige in terms of material possessions and excludes feeling and emotion. Feeling uneasy in such a climate, they feel like "escaping" from it and, therefore, turn to drug or withdraw into the inner world. But this does not lead us to conclude that disappointment leads to desperation which, in turn, to drug use automatically.

In view of these, there are other explanations also of the motivations to drug use/abuse, we shall deal with them in our concluding chapter on "social research, policy and control".

In view of these few explanations, drug use may be attributed mainly to five factors :-

1. More leisure and lack of involvement in conventional activities.
2. Attainment to drug-using peer group.
3. Person's desire to escape from personal problems.
4. Persons need to reduce tensions or overcome ugly situations.
5. Impact of mass media/and due to misinformation or even disinformation.

It may also be pointed out that drug abuse has nothing to do with :-

1. Lack of commitment to social norms and values.
2. Unrest on the college/univeristy campuses.
3. Negative attitude towards family or "establishment" or irastible urge of the youth to revolt against authority.

On the basis of the above analysis, we may classify the drug-users (who use drugs other than tobacco and pain-killers) in five groups.¹¹

1. Who are emotionally immature, impulsive, passive, dependent, easily discouraged and depressed and unable to cope.
2. Who are defiant and seek ways of antagonising persons in authority (including father or guardian⁰ because they consider them repressive and deceitful.

3. Who are seclusive and shy individuals and are labelled by psychiatrists as schizoid. They find a medical cure for their shyness in the drugs. The drugs dissolve their inhibitions and provide them with the subjective feeling of intimacy and the illusion of closeness.
5. Who are depressed, alienated and show the "antimotivational syndrome". Rather than facing and coping with the world of reality, they escape into the world of fantasy drug dreams.
5. Who come from belorable (depressing/humiliating/wretched life situations.

Now, let us look at the aspect of withdrawal attempts, if any, made by drug users. Even the past users, at least some of them, relapse into drug-habituating in case they do not possess strong will power and give them to allurements/temptation engendered by drug culture. Whatever be the situation, we have to examine, in brief, the withdrawal attempts made by our respondents, indulging in drug abuse. It may be noted that we have already deliberated on this facet of the problem in a previous chapter.

3. ATTITUDES TO DRUGS

Many who are exposed to deviant subcultures define drug use in positive terms from the beginning, or at least they are exposed to attitudes favourable to or tolerant to use. In these cases, there are few moral obstacles to overcome in coming to the point of trying liquor, or smoking a cigarette, or taking a drug for the first time.

It is, therefore, essential here to know the attitudes of non-users and ever-users (past-users and current users) towards certain aspects related to drugs.

The respondents were given seven statements to judge their reactions. Of these, two pertained to the availability of drugs, three to the effects of drugs, one to the punishment of users, and one to the cause of taking drugs. Individually, the twelve statements were : (1) All drugs should be as freely available in the market as alcohol, (2) Legal control over the possession of illegal drugs should be lifted, (3) The college administration should enforce disciplinary action against the drug users, (4) Most drug users in college are to be found among the more confused, insecure and immature students, (5) The

continued heavy use of drugs will lower academic performance, (6) Most drug users are among the more independent, thoughtful and creative students, (7) Students use drugs to defy persons who are in authority, (8) Students/hostelers are initiated into drug use (primarily motivated to drug-taking) under the impact of the modern socio-cultural milieu, (9) The greatest allurements/fascination for drugs among the youth is created by the ever-increasing impact of the mass media (including films, TV news, magazines and cheap fiction etc.), (10) Hostelers/students are often misused by politicians and others and induced to drug-taking, (11) Drug-taking, including alcohol and tobacco, has become almost a social-cultural necessity. One can escape from it after much difficulty (To refrain from taking drugs is to deprive oneself of the charms/benefits of modern life, and (12) The fanciful, adventurous and romantic forms of activities are associated with youth. It is here that drugs enter in youths' life. The reactions of the respondents are shown in Table 7.3.

TABLE 7.3**REACTIONS OF DRUG-USERS AND NON-USERS ON GIVEN STATEMENTS**

S.No.	Statements	NCN- USERS	PAST- USERS	CURRENT- USERS	TOTAL (N)
1. ALL DRUGS SHOULD BE FREELY AVAILABLE IN MARKET AS ALCOHOL					
a)	AGREE	20 (23.3)	5 (12.8)	110 (62.8)	135 (45.0)
b)	DON'T KNOW	50 (58.13)	25 (64.1)	22 (12.6)	97 (32.4)
c)	DISAGREE	10 (11.60)	6 (15.4)	33 (18.9)	49 (16.3)
d)	N.R.	6 (6.97)	3 (7.70)	10 (5.7)	19 (6.3)
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)
2. MOST DRUG USERS ARE AMONG THE MORE INDEPENDENT, THOUGHTFUL AND CREATIVE STUDENTS					
a)	AGREE	75	28	127	230 (76.6)
b)	DONT' KNOW	10	7	32	49 (16.0)
c)	DISAGREE	1	3	7	11 (3.7)
d)	N.R.	-	1	9	10 (3.70)
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.00)

TABLE 7.3 CONTD.

S.NO.	STATEMENTS	NON- USERS	PAST- USERS	CURRENT- USERS	TOTAL (N)
3. LEGAL CONTROL OVER POSSESSION OF ILLEGAL DRUGS BE LIFTED					
a)	AGREE	25 (29.0)	32 (82.0)	130 (74.3)	187 (62.3)
b)	DON'T KNOW	45 (52.3)	5 (13.0)	28 (16.0)	78 (26.0)
c)	DISAGREE	12 (14.0)	02 (5.0)	7 (4.0)	21 (7.0)
d)	N.R.	4 (4.70)	-	10 (5.7)	14 (4.7)
TOTAL		N = 86 (100.0)	N = 89 (100.0)	N = 175 (100.0)	N = 300 (100.0)
4. CONTINUED USE OF DRUGS LOWERS ACADEMIC PERFORMANCE					
a)	AGREE	60 (69.76)	12 (30.8)	88 (50.690)	230 (76.7)
b)	DON'T KNOW	15 (17.4)	22	69	36 (12.0)
c)	DISAGREE	7 (8.0)	3 (7.7)	8 (4.6)	18 (6.0)
d)	N.R.	4 (4.6)	2 (5.00)	10 (5.7)	16 (5.3)
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 9100.0)

TABLE 7.3 CONTD.

S.NO.	STATEMENTS	NON- USERS	PAST- USERS	CURRENT USERS	TOTAL (N)
5. COLLEGE ADMINISTRATION SHOULD ENFORCE DISCIPLINARY ACTION AGAINST DRUG-USERS					
a)	AGREE	60 (69.8)	28 (71.8)	46 (26.30)	134 (44.7)
b)	DON'T KNOW	30 (11.6)	7 (17.9)	87 (49.7)	104 (34.7)
c)	DISAGREE	10 (11.6)	4 (10.3)	26 (14.9)	40 (13.3)
d)	N.R.	6 (7.0)	- (0.0)	16 (9.1)	22 (7.3)
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)
6. DRUG USERS IN COLLEGES ARE MORE CONFUSED, INSECURE AND IMMATURED STUDENTS					
a)	AGREE	70 (44.7)	22 (56.4)	17 (9.7)	109 (36.3)
b)	DON'T KNOW	10 (34.7)	10 (25.6)	148 (49.3)	168 (56.0)
c)	DISAGREE	3 (13.3)	5 (12.8)	6 (3.4)	14 (4.7)
d)	N.R.	3 (7.3)	2 (5.2)	4 (2.0)	9 (3.0)
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)

TABLE 7.3 CONTD.

S.No. STATEMENTS	NON- USERS	PAST- USERS	CURRENT USERS	TOTAL (N)
7. HOSTELERS/STUDENTS USE DRUGS TO RELIEVE TENSION, OVERCOME FATIGUE AND DRUSTRATION				
a) AGREE	49 (57.0)	22 (56.4)	148 (56.4)	219 (73.0)
b) DON'T KNOW	10 (11.6)	7 (17.9)	17 (17.9)	34 (11.3)
c) DISAGREE	12 (14.0)	3 (7.7)	8 (7.7)	23 (7.7)
d) N.R.	15 (17.4)	7	2 (18.0)	24 (8.0)
TOTAL	N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)
8. STUDENTS/HOSTELERS ARE INITIATED INTO DRUG US (OR MOTIVATED TO DRUG-TAKING) UNDER THE IMPACT OF THE MODERN SOCIO-CULTURAL MILIEU				
a) AGREE	20 (23.3)	13 (33.3)	116 (66.3)	149 (49.7)
b) DON'T KNOW	32 (37.2)	23 (59.0)	18 (10.3)	73 (24.3)
c) DISAGREE	18 (20.9)	2 (5.1)	27 (15.4)	47 (15.7)
d) N.R.	16 (18.6)	1 (2.6)	14 (8.0)	31 (10.3)
TOTAL	N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)

TABLE 7.3 CONTD.

S.NO.	STATEMENTS	NON- USERS	PAST- USERS	CURRENT- USERS	TOTAL (N)
9.	THE GREATEST ALLUREMENT/FASCINATION FOR DRUGS AMONG THE YOUTH IS CREATED BY THE EVER-INCREASING IMPACT OF THE MASS MEDIA (INCLUDING FILMS, TV NEWS MAGAZINES AND CHEAP FICTION ETC.)				
a)	AGREE	60 (69.8)	20 (51.3)	140 (80.0)	220 (73.4)
b)	DON'T KNOW	15 (17.4)	12 (30.8)	15 (8.6)	42 (14.0)
c)	DISAGREE	10 (11.6)	5 912.8)	16 (9.1)	31 (10.3)
d)	N.R.	1 (1.2)	2 (5.1)	4 (2.3)	7 (2.3)
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)
10.	HOSTELERS/STUDENTS ARE OFTEN MISUSED BY POLITICIANS AND OTHERS & INDUCED TO DRUG-TAKING.				
a)	AGREE	10 (11.6)	15 (38.5)	137 (78.3)	162 (54.0)
b)	DON'T KNOW	70 (81.4)	20 (51.3)	23 (13.1)	113 (37.8)
c)	DISAGREE	4 (4.6)	2 (5.1)	10 (5.7)	16 (9.2)
d)	N.R.	2 (2.4)	2 (5.1)	5 (2.9)	9 (3.0)
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)

TABLE 7.3 CONTD.

S.NO.	STATEMENTS	NON- USERS	PAST- USERS	CURRENT USERS	TOTAL (N)
11.	DRUG-TAKING, INCLUDING ALCOHOL AND TOBACCO, HAS BECOME ALMOST A SOCIAL-CULTURAL NECESSITY. ONE CAN ESCAPE FROM IT AFTER MUCH DIFFICULTY. (TO REFRAIN FROM TAKING DRUGS IS TO DEPRIVE ONESELF OF THE CHARMS/BENEFITS OF MODERN LIFE)				
a)	AGREE	80 (93.0)	36 (92.3)	170 (97.1)	286 (95.3)
b)	DON'T KNOW	4 (4.7)	2 (5.1)	3 (1.7)	9 (3.0)
c)	DISAGREE	2 (2.3)	1 (2.6)	2 (1.2)	5 (1.7)
d)	N.R.	-	-	-	-
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)
12.	THE FANCIFUL, ADVENTUROUS AND ROMANTIC FORMS OF ACTIVITIES ARE ASSOCIATED WITH YOUTH. IT IS HERE THAT DRUGS ENTER IN YOUTHS' LIFE				
a)	AGREE	50 (58.2)	28 (71.80)	170 (97.1)	248 (82.7)
b)	DON'T KNOW	25 (29.0)	6 (15.4)	2 (1.2)	33 (11.0)
c)	DISAGREE	5 (5.8)	2 (5.1)	3 (1.7)	10 (3.3)
d)	N.R.	6 (7.0)	3 (7.7)	-	9 (3.0)
TOTAL		N = 86 (100.0)	N = 39 (100.0)	N = 175 (100.0)	N = 300 (100.0)

The figures show that 53.7 per cent drug-users did not want free availability of drugs in the market, 15.42 per cent were against lifting of legal control over the possession of illegal drugs, and 34.6 per cent were in favour of enforcing disciplinary action against the users by the college administration. As regards effects of drugs, 42.5 per cent drug-users thought that drugs lowered academic performance, 18.2 per cent felt that drug-users are confused, insecure and immature students, and 81.8 per cent did not view drug-users as independent, thoughtful and creative students. Lastly, when 11.12 per cent ever users felt that students did not use drugs to defy people in authority, 79.4 per cent did not think so.

The attitudes to drugs were analysed to test the hypothesis that the more favourable the attitudes towards drugs that students hold, the more likely they are to take drugs. The null hypothesis that there is no significant difference between the two groups of users and non-users in their attitudes to drugs and drug-users was found invalid, and the hypothesis that drug-takers have the more favourable attitudes to drugs was supported.

A further analysis was carried out in which users and non-users were compared on each of the twelve items. This was to see if there were any significant differences on any of the specific opinions about drugs and drug users. The number and percentage of each of the two groups which agreed with each of the items is given in Table 7.4.

The table shows that on first two of the twelve items, there was a significant difference between the drug-users and the non-users. These figures, thus, point out that : (1) drug-users, by and large, are not conformists" in their views. They are drifting away from traditional mores ; and (2) their views are quite different from those of the post or non-users. As such, it could be said that it should not be very difficult to 'treat' these aberrants. But who will treat them and how. Efforts so far made in this direction have borne some encouraging results. By and large, these efforts have so far fallen much short of the requirements in the context of their ever-complex situation on the scene of drug meance. Some western countries, including the U.S.A. and also some Third World countries are currently bedevilled with the drug-addiction epidemic. The drug pedlers, drug

TABLE 7.4**ATTITUDE OF "AGREEING" WITH THE GIVEN STATEMENTS BY DRUG-USERS AND NON-USERS**

S.NO.	STATEMENTS	USERS	NON-USERS	χ^2 VALUE
1.	ALL DRUGS SHOULD BE FREELY AVAILABLE IN MARKET	115 (53.7)	20 (23.3)	1.89
2.	MOST DRUG-USERS ARE INDEPENDENT, THOUGHTFUL STUDENTS	155 (72.4)	75 (87.2)	5.66
3.	LEGAL CONTROL OVER POSSESSION OF ILLEGAL DRUGS BE LIFTED	162 (75.7)	25 (29.0)	1.74
4.	CONTINUED USE OF DRUGS LOWERS ACADEMIC PERFORMANCE	170 (79.4)	60 (69.8)	5.20
5.	COLLEGE ADMINISTRATION SHOULD ENFORCE DISCIPLINARY ACTION AGAINST DRUG!USERS	74 (34.6)	60 (69.8)	3.42
6.	DRUG USERS ARE MORE CONFUSED, INSECURE AND IMMATURE	39 (81.2)	70 (81.4)	10.21
7.	STUDENTS USE DRUGS TO DEFY PEOPLE IN AUTHORITY	170 (79.4)	49 (56.9)	0.31
8.	STUDENTS HOSTELERS ARE INITIATED INTO DRUG USE (OR MOTIVATED TO DRUG-TAKING UNDER THE IMPACT OF THEMOERN SOCIO-CULTURAL MILIEU	129 (60.3)	20 (23.3)	0.09
9.	THE GREATEST ALLUREMENT/FASCINATION FOR DRUGS AMONG THE YOUTH IS CREATED BY THE EVER-INCREASING IMPACT OF THE MASS MEDIA (INCLUDING FILMS, TV NEWS, MAGAZINES AND CHEAP FICTION ETC.)	160 974.8)	60 (69.8)	6.93
10.	HOSTELERS/STUDENTS ARE OFTEN MISUSED BY POLITICIANS AND OTHERS AND INDUCED TO DRUG-TAKING	152 (71.02)	40 (11.62)	20.74
11.	DRUG-TAKING, INCLUDINGS ALCOHOL AND TOBACCO, HAS BECOME ALMOST A SOCIAL-CULTURAL NECESSITY. ONE CAN ESCAPE FROM IT AFTER MUCH DIFFICULTY. (TO REFRAIN FROM TAKING DRUGS IS TO DEPRIVE ONESELF OF THE CHARMS/BENEFITS OF MODERN LIFE)	206 (96.3)	80 (93.0)	22.28
12.	THE FANCIFUL, ADVENTUROUS AND ROMANTIC FORMS OF ACTIVITIES ARE ASSOCIATED WITH YOUTH. IT IS HERE THAT DRUGS ENTER IN YOUTHS' LIFE.	198 (92.5)	50 (58.1)	66.62

$$= \frac{(f_0 - f_1)^2}{f_e} = x^2 \text{ chi} = x^2 \text{ T.V.} = 19.675$$

smugglers, drug mafias who are more dreaded by the people especially the drug abusers, carry on their nefarious activities against the country and the people, while openly working for the expansion of their drug-culture empire.

DRUG-USE AS LEARNED BEHAVIOUR

Several explanations of causes of drug use have been suggested - physiological, psychological and social. Physiological explanation has not found empirical support (Greenbert², 1958 : 30, Straus³, 1966 : 263). This conclusion is equally applicable to the research that has attempted to locate some personality pathology, characteristic or type which makes a person prone or susceptible to drug use. No personality characteristics consistently differentiate drug users from non-users, and research has failed to find a distinctive or unique "drug user personality type."

2. Greenberg, op. cit., 1958, p. 30.

3. Straus, Robert, in *Contemporary Social Problems*, (ed) Robert Marton and Nisbot, Harcourt Brace, New York, 1966, p. 263.

Drug smuggling with international ramifications, has been alleged to being deeply and intricately involved in these nefarious games, one are the other way. The whole picture does not seem to be savoury for close observers of the world scene. The drug manufacturers and traders have very close links, internationally with drug mafias and terroriorists. Unfortunately, during the recent past (Fifties onward) the politicians and bureaucrats have formed **'cartles'** with the above elements. Both terrorism and crimes, mainly economic, b y a clandestime sex-exploitation, political intrigues, offence surfacing up in the form of local, regional wars, coup-de-tats and 'revolutions'.

A large number of social psychologist, and Sociologist (including their social engineering variant) pinned, for a long time, their faith to marxian theory of alienation to explain drug abbersion. We would like to concur with erich good regarding the inadequacies of this approach. He concludes by saying "alienation is most complete under a condition of ideological and moral monopoly." Further, he says, "A larger and a larger number of scientist and physicians are realising the ideological

implications of their work and are no longer willing to be employed as propagandists to shore up a crumbling and changing moral structure.⁴ Thus, what were once isolated pockets of unconventional behaviour (deviance) have become organised communities of deviants ascertaining the right of their own way of life.⁵

Marxian and new-marxian theory of alienation to explain drug culture has been criticised in many counts. Alienation, however, is a double-edged sword. Dissident sub-cultures create alienative mechanisms of their own. In his book on heroin addicts, Seymore Fiddle used the term "existential drugs" - drugs that are used to that the limits of human freedom, to push out beyond the narrow confines of the arbitrary social definitions of right and wrong, true and false.⁶ But if some heroin addicts experiment with drugs as an expression of human freedom, they ironically trap themselves into a more narrow and alienated life than they experienced previous to using drugs. They act out a more stereotyped role than ever before - that of the street junkie. Any culture or sub-culture is to some degree alienative ; it always presents a relatively limited number of options to its

4. Erich, Good, **Drugs in American Society**, p. 233.

5. *Ibid*, p. 233.

6. Erich, Goode, *op. cit.* pp. 234-235.

members. (The range of alternatives obviously varies from one culture to another). Some degree of social pressure will always exist, everywhere and at all times. Thus not only drugs can lead to "alienation" through dependence - producing a "shrunk" one dimensional man", but deviant sub-cultures can also alienate in much the same way the dominant cultures alienate - by defining their view of reality as right and legitimate and discrediting others, by constructing their own "hierarchy of credibility."

It is impossible at this point to determine, says Erich Goode, whether permissiveness in regard to drug use will produce a more rewarding society or social catastrophe. Societies have an enormous capacity for absorbing and transforming behaviour and beliefs that on the surface appear to be a radical departure from established patterns.

Drug ideologues who claim that psychedelic drug use is inherently revolutionary are mistaken as tradition lists who believe that psychedelic drugs will destroy society as we know it. Knowing that it is impossible to "stamp out" illegal drug use, we should turn our attention to dealing with drug use as we now have, and

will continue to have. Whether this attempt is a productive effort or a failure is our decision. Those in power have less often made wise decisions than poor ones, and drugpolicy over the next few years will almost certainly be no exception to this rule. Most of us will weather this blunders ; some will not. It is probably naive to hope for a more rewarding and less repressive society in the face of current trends, but optimism in more satisfying attitude than despair.

Some sociologists have maintained that drug abuse is a response to stress, tension and anxiety. Hence, the relation of the socio-cultural milieu to drug use is seen in the degree to which it exposes the people to stressful or anxiety-provoking situations. Although different terms are used, the various social characteristics posited as setting up stress-inducing situations conducive to drug-taking can be subsumed under the concept of **anomie** or **disorganisation**.⁷

Anomie produces aambivalence which supposedly produces anxiety, which in turn leads to drug taking.

7. R. Ahuja & Others, **Drug Abuse Among College Students**, 1987, p. 99.

Bales⁸, Ullman⁹, Synder¹⁰ and Straus¹¹, etc. have all explained alcoholism as a manifestation of stress-producing conditions. Similarly, it has been mentioned that the more disorganised are the social conditions to which persons are exposed, the higher is the probability of drug abuse. To support this conclusion, evidence has been cited showing the low rates of drug abuse in societies with integrated kinship structures compared to the high rates in societies with more fragmented kin systems. Drug abuse has, thus, been linked to conditions of anomie and its relative absence to socio-cultural integration.

Viewing anomie as one type of structural formational condition, it has been related to the learning theory (Conger¹², 1956, 1958). The theory is that ambivalence produces anxiety, drugs relieve anxiety ; and

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8. Bales, Robert F, "Cultural Differences in Rates of Alcoholism" in Quarterly Journal of Studies on Alcohol, 1949, pp. 480-99.
 9. Ullman, Albert D., "Socio-cultural Backgrounds of Alcoholism" in Annals, Jan. 1958, pp. 48-54.
 10. Synder, Charles R., Anomie and Deviant Behaviour, ed. by Marshall B. Clinard, Free Press, New York, 1964, pp. 189-213.
 11. Straus, Robert, op. cit., pp. 236-80.
 12. Conger, John H. "Reinforcement Theory and the Dynamics of Alcoholism" in Quarterly Journal of Studies on Alcohol, June 1956, pp. 296-305.

this experience is rewarding and reinforces further drug use. Thus, those who are anxious and who have access to drugs will more often be rewarded in this way and become drug addicts. Conger's need-reduction theory is that drug use is behaviour negatively reinforced by drug's reduction of anxiety or fear rather than behaviour positively reinforced. The evidence tends to support the contention that drug addicts take drugs more for personal effect, whereas occasional or casual drug users tend to take drugs for the social rewards connected with drug taking.

This learning theory based on the concept of anomie can be challenged in many ways. First, the meanings of integration and anomie are not always clear in sociological literature. Secondly, anomie cannot be measured. Thirdly, this theory does not explain the "social rewards" which the casual drug taker will get. Fourthly, it does not give importance to "social control" in preventing desire from taking drugs. Fifthly, use of "recreational" drugs can not be linked with anxieties and strains. Lastly, many addicts soon realise that drug use is not mechanism that reduces anxiety.¹³

On these grounds, we feel that we require a new paradigm and a new perspective to explain drug abuse theoretically. In the following pages, an attempt has been made to cope with the available but not so savoury a task.

4. A SUGGESTED PARADIGM

In reviewing the data in our investigation, two dimensions could be observed may be used to explain the extent of drug use in the student (i.e. youth or hostelers) population. The data shows that the drug use can vary along a continuum from 'no use' of any drug to 'daily use' of (and dependence on) a variety of drugs⁹. The extent of drug use, thus, can be conceptualised along two dimensions : type of drug and frequency of drug use.

DIAGRAM 1

RELATION BETWEEN TYPE OF DRUG & FREQUENCY OF DRUG-USE

Type of drugs	Frequency of drug-use	
	Seldom	Frequent
One drug only	a	b
Poly drug (many drugs)	c	d

All youths (hostelers) can fall into one of the four cells - a, b, c, or d. Obviously, the youths hostelers, who fall into cell 'd' are much more likely to become 'problem cases', while those in cell 'a' present little or no problems either to themselves or to society. 'b' and 'c' are intermediate stages between the two extremes.

Let us redesign this paradigm for predicting the extent of drug use. This paradigm takes into account, on the one hand, the degree of integration or three factors in the person's behaviour, viz. adjustment (in status), attachment (to values) and commitment (to roles) and, on the other hand, the attitude towards drug use.

Adjustment refers to the smooth switch over from one status to other, perceiving one's role as perceived by others, an active participation in all roles, and having a problem-solving attitude. **Attachment** is the bond of affection between an individual and other (conventional) persons. The degree of attachment is how much the person cares for others, and is cared for by them, and how much the person values others' feelings, opinions and expectations. **Commitment** is a feeling of obligation to seek a particular goal or to follow a particular course of action.

Maladjustment, unattachment and non-commitment are to be examined in terms of individuals background factors as well as his socialised personality. Our basic hypothesis is that the potential for drug abuse varies strongly with the degree of integration in society

(family, college, hostel, peer group, etc.), i.e. adjustment/attachment and commitment of the individual and his favourable and unfavourable attitude towards drug use.

DIAGRAM 2

PARADIGM PREDICTING EXTENT OF DRUG-USE

		<u>Attitude towards drug use</u>	
		<u>Favourable</u>	<u>Unfavourable</u>
<u>Degree of Integration</u>	<u>Low (x)</u>	<u>Highest (a)</u>	<u>Intermediate (b)</u>
or			
<u>Extent of adjustment, attachment and commitment in society</u>	<u>High (y)</u>	<u>Intermediate (c)</u>	<u>Lowest (d)</u>

The first dimension is the youth's (boy or girl) integration (adjustment, attachment and commitment) in society. This can be measured by the youth's degree of satisfaction he or she receives from social contacts. Thus, if the youth does not participate in family activities or receives little gratification from these contacts, he or she would be classified as 'low' on that

dimension, conversely, higher gratification from contacts would be classified as 'high'.

The second dimension is the youth's perception of his attitudes towards drug use. These attitudes may range from 'favourable' to 'unfavourable'. If, for instance, the youth has a father or a brother in his family or close friends in his peer group who use drugs (take alcohol, smoke cigarettes or consume drugs) he or she might reasonably perceive that their attitudes toward drug use are favourable and as such he himself might develop similar favourable attitude towards use of drugs. Our paradigm, then, would predict that as one moves from high (y) **integration** to low (x) integration, and from 'unfavourable' to favourable' self and primary group attitudes towards drugs, the extent of drug use will increase, i.e., lower the integration and higher the favourable attitude toward drug, higher will be the drug use and vice-versa.

Let us take the data from our survey about different types of youths (boys and girls) and see if it fits into our paradigm. One type of youth garnered from our survey is one who feels alienated from his family (i.e. thinks that his parents are not taking interest in

his career or there is little parental control over him) and who interacts mostly with drug users (who smoke, take alcohol or consume drugs). This youth clearly fits into cell 'd'. If his father or brother(s) use drugs, this is even more reason for him to feel that there is no harm in taking drugs. Conversely, suppose there is a youth who comes from an 'affectionate' family and family which does not use cigarette or alcohol even and who is committed to hard work in studies (role commitment), this individual could be easily placed in cell 'a'.

A youth whose family members do not smoke or take alcohol and whose parents properly nurture him but whose friends are mostly those who smoke or take alcohol or drugs, may be placed in cell 'b' or 'c'. It is individuals in group 'd' who should constitute the targets for prevention and/or treatment. The major point is that by knowing the individual's degree of 'integration' (adjustment, attachment and commitment) and the orientation of his or her primary groups (family or peer groups) towards drug use, we can predict extent of drug use.

While operationalisation of certain concepts and variables (like adjustment, attachment, commitment, etc.) may not be considered easy but, nevertheless, it is not very difficult too. As such, our paradigm does seem to place drug use in a social context and predictions based on it do seem to be consistent with "youth drug use".

CHAPTER - VIII

EPILOGUE : DRUG ABUSE, RESEARCH : SOCIAL POLICY & CONTROL

CHAPTER - VIII

DRUG ABUSE RESEARCH, SOCIAL POLICY & CONTROL

What can be deduced from this investigation as a whole ? It must first be pointed out that as this investigation included all faculties and all colleges and university departments in the city, it is fully representative of the resident student population (hostelers) as a whole. Secondly, the total number of resident students studied is fairly large for a single man conducted study that it will not be wrong to generalise. As such we can make some inferences from the findings of this investigation.

1. THE FINDINGS

Focussing on trends from a 5 year period - 1986 to 1990, the highlights noted in our investigation are :-

(1) The epidemiology of drug use has changed its character. Two fairly subtle changes discernible are (a) an increase of rates for almost all substances except heroin, and (b) a heterogenisation instead of homogenisation of resident student population using drugs.

(2) The past few years have witnessed significant increase in heroin and brown sugar use with a

- concomitant increase in the proportion of hostellers using other illicit drugs.
- (3) Heroin, smack, hashish, cocaine, tranquilizers, stimulants and sedatives, i.e., hard drugs or the psychotropic substances rank far below alcohol and nicotine in terms of illicit drug use and abuse.
 - (4) In the five year span (from 1986 to 1990), the rate of alcohol drinking among male students has increased from 39.8 per cent to 45.8 per cent and among females from 20.5 per cent to 22.8 per cent, while cigarette-smoking among females has increased from 6.4 per cent to 11.4 per cent and among males from 39.0 per cent to 50.1 per cent.
 - (5) The vast majority of resident students are experimental users and users of recreational drugs. Heavy or regular use is found in a small minority of drug users.
 - (6) Differences in drug use rates across demographic sub-groups are more significant today than in former years.
 - (7) Most of the drug users are not 'alienated' from their families ; some of them have parents and siblings, who use drugs. But most often, they have peers who either use drugs or support drug use.

- (8) Drug abuse depends upon social settings and cultural and social attitudes of the users, i.e., differences between users and non-users may be attributed not only to their personality characteristics but also to their differences of being free from social restraints. In simple terms, the use of any drug involves values, social sanctions (rules of conduct) and behaviour patterns.

2. TESTING OF HYPOTHESES

We had formulated some hypotheses (Chapter-II) pertaining to drug use/abuse/misuse. Of the 11 hypotheses, five were found valid, three were marginally proved, and two were rejected. The valid hypotheses are :-

- (1) relationship between drug abuse and course background ;
- (2) relationship between class of study and drug abuse
- (3) sex differentials of drug abusers ;
- (4) drug users dependence on family income ;
- (5) drug users' association with the peers ;

The unsupported theses are :-

- (6) correlation between drug abuse and affluence ;
- (7) relationship between drug-abusing children with their parents ; having interest or otherwise in their wards ;
- (8) interest of drug users in curricular/co-/extra curricular activities ; and
- (9) drug abusers/users academic performance ;

The marginally supported verified hypotheses are:-

- (10) association between drug use and affluence ; and
- (11) association between family/parental/guardian control and drug users.

3. PROBLEMS OF EFFECTS OF DRUGS

The increase in the magnitude of drug use has accentuated the problems and effects of drug use. We may point out four problems pertaining to intended and unintended effects of drug taking.

- (1) It arises from the unintended effects of medically prescribed drugs or over-the-counter drugs (pain killers, barbiturates, amphetamines,

tranquilizers, etc.). Drugs prescribed by doctors are for preventing or curing disease or alleviating some ills. There are, however, very large number of adverse reactions to these drugs which are just as harmful to the individual as international misuse of drugs.

[2) It concerns us most and relates to misuse, abuse and/or addiction of drugs. Effects of drugs obtained from street peddlers to maintain a habit are brought about by individual decision to escape from the reality of the external or the internal world. The origin of this type of the therapeutic use of drugs is directed primarily against a drugs (hereoin, marijuana, cocaine, cannabiss, LSD, etc.) is primarily to create a change in feeling, usually pleasure or at least the absence of an unwanted feeling. These drugs contain contaminants or toxic matter of harmful concern.

(3) It arises from the effects of the recreational use of drugs, or drugs for which no prohibition or social sanction against their use exists and which are used for relaxation, fun or to get away from

the stresses and strains of life. They are, from the standpoint of law, netural even though restrictions on their distribution decrease their abuse somewhat. Alcohol and tobacco are the examples of recreational drugs.

- (4) It relates to the causative relationship between the use of nicotine and other drugs and hundreds of thousands of deaths and disabilities each year due to the dreaded diseases of lounq cancer, heart disease, hypertension, brochitis, etc. is well established.

4. TREATMENT AND REHABILITATION OF DRUG ABUSERS

The problems and effects of drug abuse have drawn worldwide attention to treatment programmes¹. It is difficult to judge which of the present methods of treatment is the best. Drug abuse/addiction is an individual problem as well as a social problem and one cure will obviously not help every abuser or the multiple variants of the vexed. There are so many types of social problem from drugs, so many types of abusers and so many motivations of abuse that the curative process has to

1. Blachy, Paul, Drug Abuse, page 283
 Bean, Philip, The Second Control of Drugs, page 96.

consist of offering to the abuser/addict the most beneficial method for him specifically. And specific methods/procedures are, similarly, required to cope with the differentials of this social problem.

There are certain drugs (like amphetamines, tranquilizers etc.) which are taken to increase work output, to cause wakefulness, to increase physical activity, and to develop tolerance, etc. The ordinary dose of these drugs varies from 2.5 mg to 15 mg. per day but their chronic use amounts from about 50 mg. to well over 1,000 mg. per day. Many abusers begin with low doses but slowly increase their dosage upto 150 or 250 mg. per day. The speed is shot because it is pleasurable.

Treatment concepts and programmes have, thus, grown out of the demands of the times most recently in response to the increasing rate of drug abuse use among different populations and the comparative failure of more traditional means of coping with drug dependency.

Earlier, certain narcotics were used to cure some other abuse of narcotics, e.g., heroin was used to treat morphine dependence. But researches soon pointed out mistakes in medical expertise and fallacy or treating

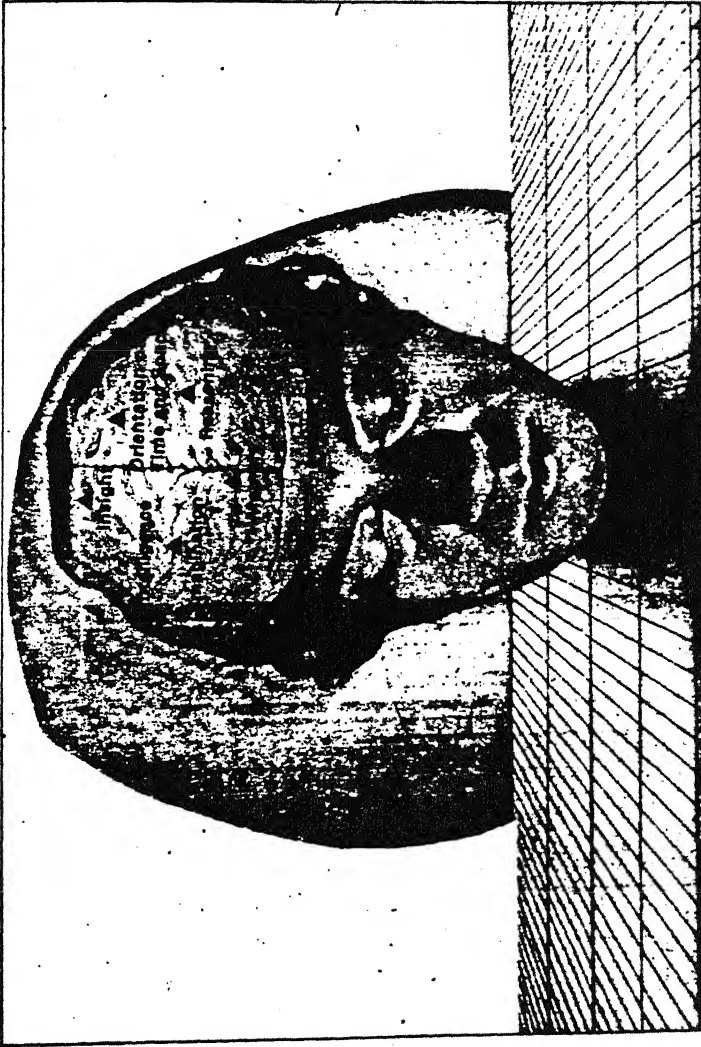
नशीली दवाओं का फैलता नरक

जैसे-जैसे देश में आप्रानिकता बढ़ती जा रही है, वैसे-वैसे चरम, सैक, एनएसडी आदि छतानाक नशों का जाल भी फैलता जा रहा है। इन नशों के सौदागर और तकर यह प्रचार करते हैं कि इनसे तनाव कम होता है या स्फूर्ति मिलती है। सवाइ इसके ऊपर है। शारीरिक, पारिवारिक और सामाजिक स्तर पर इनका किताब विनाशकारी असर पड़ता है, बता रहे हैं डॉ. यतीश अग्रवाल ।

[illegible]

इसके साथ ही सामाजिक-आर्थिक हानि
होने लगी। इसी परिणाम के लिए यह
दुष्टता में बढ़ती जा रही है।
जहाँ तक 'विदेशी' के दो रूप
हैं। 'वस्तु' का, 'विदेशी' को परम्परागत
निर्भरता के अन्तर्गत है, 'प्राप्त' मिलने से
रोकना पड़ती है। ऐसे 'विदेशी' का अर्थ
है। 'प्राप्तता' का-क्या, 'काम' की-
निर्भरता में अन्तर्गत।
पर दूसरा रूप का है किसे 'प्राप्त'
पड़ता है और काँड़ी अन्तर्गत
आवश्यक है। इस निर्भरता में निर्भरता इस
कारण बढ़ जाती है कि आगामी 'प्राप्त' न
होने, जो अन्तर्गत से प्राप्त होना है अन्तर्गत
है। प्राप्ति के रूप में जो पड़ने वाले
हैं, अन्तर्गत अन्तर्गत आती है, किन्तु अन्तर्गत
है, प्राप्ति निर्भरता ही सम्बन्ध बढ़ती रहती है।
आगामी अन्तर्गत निर्भरता में सम्बन्ध बढ़ती है।

आता है, पर सिर्फ कुछ देर के लिए।
 श्री-और झुण्ड की भाता धड़ती जाती है।
 शरीर के लिए नारा एक अकसरत मन जाता
 है। अकस्मिक, स्नेह (माउस शोर), गंध,
 यह धारणा सही नहीं है कि
 सुरा-फरेम जाने वाले अभीर पतनों के
 लड़के की नाराबादी के विपरीत होते हैं। नारा
 करते बालों में आज हा किसी लकड़े ओर



दी. तर्क. इति. वाक्यान्त और कल्पना पर नशीली दवाओं के असर की चित्रकार की कल्पना

जाने उसे छोड़ देंगे। ज्यादातर शाकभक्त
जाता है।

मिनी टोपल या सावरी के बने ये अम्क लोपी
 है। कुछ लोग राखण, जीवन की
 कराशाम्क और तालव या पम्कन दु कदने
 के लिए भी रक्कम सम्कन कदने सारते हैं। पर
 अम्कन कदने के बाद सब अम्कन कदने
 पण कर देते हैं। जीवन में प्या की कमी
 ठेकी पण उनम्की से प्या पूरु अम्कन
 से उणत पण से लिए और इतिवस्स प्या
 हुने के बादने भी कुछ लोग पण के प्या
 है कि तालवरी प्याम्की से लेने से सारते हैं।

डालते हैं। प्रथम बार जाती है तो वजन गिरने लगता है। शरीर कमजोर हो जाता है और हृत्पम्पन से धावने के कहींबल नहीं रहता। व्यायाम करने वालों में हार्मोनल टीबी और दूसरे संक्रामक रोग ज्यादा पाए जाते हैं। नरस में इन्जेक्शन लगानाकर नरस करने वालों में पीलिया (हेपेटाइटिस-बी) भी हो सकता है। यों एड्स की आशंका भी रहती है। ये पदार्थ पुरुष में यौनकमला भी उत्पन्न कर देते हैं।

इनके लिये रहने से एकग्रामता और
याददास्त पर बेहद खराब असर पड़ता है ।

इस संकल्प उसके पारिवारिक और समाजिक जीवन पर भी असर होता है। उसके संबंधों में निष्ठाएव आ जाता है, वह प्राग्-पैटने पर उतार रहता है और नतीजातन वह अपने-अपने का साथ खो बैठता है।

इससे वह अपने को और ज्यादा अलग-थलग महसूस करता है। इसके साथ ही आर्थिक समस्याएं भी पैदा होती हैं। आगली छुट्टाक जुटाने के लिए वह कुछ भी करने के लिए तैयार रहता है- खोटी, नशीब

पुढार्थी बडे बिहारी, तल्लरी, कुठ भी ।
इससे वह फिर और ज्यादा दलदल में फसता

[illegible]

मरफिया, पोर्बंदर, अफगान, हेरेण्डन का
नाम करते हों मरफिया के लिए ऐसी दवाएं भी
उपलब्ध हैं। इनसे मरफिया को दुरुस्त नरो के
गर्त में गिरते से बचाया जा सकता है। इनके
लेने से मरफिया पुराने शरीर पर असर नहीं
करा करता। पर ये दवाएं भी
मरने पर फलदायक नहीं होती हैं।
होती हैं।

पाश्चात् कोशिला के अन्धकार, बर्षा सीमा
 कुछ अन्धकार का नशा न करते के अन्धकार
 उस अन्धकारमय दुनिया से नौट करो ।
 उनका इन्कार का सम समुद्र एक मुक्ति
 होती है ।

ऐक्यमान के लिए इसकी मूल सीढ़ी को, माता-पिता और शिक्षकों को समझने पर सज्जा होना पड़ेगा। मूल सीढ़ी को समझने कि वह किसी रूपमें कहां आने से बना रही।

१. एक ही प्रकार
 के दो वस्तुओं के बीच
 जो संबंध है, उसे समानता
 कहते हैं।

से बहुत कम जानकी को । उनकी
 समझना ही को मुने और समझी । - ३६
 समझने में खट को । उनकी समझने को
 और दासों के को में समझने को । - ३७
 निम्न जैसे भी को । समझ निम्न । - ३८

symptoms rather than causative/motivating factors. Similarly, narcotic clinics were established to provide for brief effects of drug abuse. These clinics distributed narcotics to registered addicts. But once again it was realised that furnishing of narcotic drugs to an addict merely to satisfy his addiction is not bonafide medical treatment of disease or addiction.

As such, two treatment modes are now being used for treating drug dependence. The **clinical treatment method** and the **short period camps** for certain types of addicts. The community's desire to get the addict off the street which needs providing community treatment facilities. The **psychiatric centres** in hospitals and some specialised private clinics provide special diagnostic facilities and treat dependence through medication. The treatment in these camps mainly consists of physical withdrawal from drugs, work assignments and limited individual psychotherapy.

5. SUGGESTED PROGRAMME FOR TREATMENT²

With the increase in drug use, there is bound to be somewhat proportionate rise in drug abuse. In drugs, tobacco is our the drug problem (first), alcohol use rates (second) and the use of various 'illegal' and 'unaccepted' drugs (third). The recent problem in drug abuse is

connected largely with this group of illegal and unaccepted drugs, the consumption of what results vary often in physical and mental impairments and dreaded faral hooch tragedies.

We here below suggest a four-level programme to cope with the rising rate of drug-related problems. This programme could fit into the existing structures in our society. Models for the four levels of the proposed programme are today in existence. What is needed is co-ordination between these four levels and expansion of the programme on a national scale. Many of the present institutions could be adapted to this programme by changing their approach therapeutio procedures and underlying attitudes to drug related problems. The emphasis of the programme is on a humanistic approach.

(a) Community-based Centres

Community-based centres will provide direct services to the community. The organising staff, excluding the medical staff, should consist of young post-graduates in Sociology/Social work/Psychology or other related fields. A short training should be provided to this young staff in

handling drug users, talking to their family members, police agencies, and health personnel, etc. These workers would help the centre inmates with their peculiar personal problems as well as work to improve the environment of the families of the users and local community in general. The drug related problems cannot and should not be separated from the general problems of the community. Even non-professional ex-durg users can be appointed in these centres who can profitably act as 'therapists' and group leaders. The centres can organise (a) meeting of users and non-users to frankly discuss the issues and (b) to coordinate their activities. The drug user will stay in the centre only for a short time while workers help him to solve his individual problems. The workers should be subjected at suitable intervals to short refresher or reorientation course, so as to equip them with fast developing advanced drug treatment strategies and therapeutics.

The community centres will use "attitude control" methods. Social attitudes toward drugs sometimes are ambivalent, contradictory and confused.

Attempt should be made to refashion these attitudes through socially-oriented extra medical/extra psycliation treatment rather than medical and psychiatric treatment. This method rejects the disease concept in reference to characerising drug abuse as a behavioral problem or escape mechanism.

Therapeutic community approach is (a) a challenge to strictly medical and psychiatric treatment approaches, (b) a disbeliaver in physiological detoxification or withdrawal syndrome. It believes in psychoanalytical approach to drug abuse in terms of earlier childhood events or resurrected "oedipal" conflicts of adolescence. Rather, it stresses self-help programming, and places the addict in a 24-hour milieual setting directed by "volunteers" including ex-addicts serving as role models. Through group encounters, seminars and ventilating sessions, the addict's values and way of life are extensively questioned. The rapeutic communities are, thus, oriented to a socio-moral code which is more rigid than any in the middle class. There is a severance of ties with the outside world which helps strengthen self-help organisation's primary group nature. The closeness that

develops among the inmates may be described as a "joint family" with a system of rewards and punishments built in as a means of social control. It may simply be described as individual change through a unique communal living milieu.

The use of ex-addicts as therapists/counselors has certain advantages (i) the ex-addict acts as a role-model and the inmate-patient considers the life-style of abstience from drugs as more attainable, (ii) the ex-addict immediately establishes trust relationship with the inmate patient which is extremely necessary in the initial state, (iii) the ex-addict/abuser knows the codes, jargon and the value system of the community.

The effectiveness of therapeutic communities such as Synanon, Phoenix House, and Daytop Village has not been fully evaluated. The tentative data indicate that as a means of rehabilitating the addict, they are experimental and promising, but extremely variable in their outcome.

Proponents of the therapeutic community approach feel that methadone does not deal with the addict's underlying problems, that it eliminates only superficial symptoms. The addict is not really "cured" by the drug ;

he is still addicted to, and dependent on, a chemical. He is just as lonely and insecure, just as sick and frightened, just as immature and alienated, as he was prior to using methadone. The therapeutic community seeks as its goal a completely drug-free existence, as well as the psychiatric cure of the underlying emotional problems that impelled the addict to use drugs in the first place. Narcotic addiction is seen as largely.

"A symptom of a character disorder which results from or is exacerbated by faulty socialization of the person. The individual suffering from this form of disorder typically reacts to....stress by withdrawing into a protective shell, namely, drugs. This kind of behaviour is seen as immature, and as reflecting problems of felt inadequacy or incompetence in dealing with stress. In response to these feelings of "shithood", the addict overcompensates by developing an inflated self-image and a false sense of superiority. Consequently, he does not relate openly and honestly with others, attempts to manipulate them through a show of dependency, and lacks any real concern for them (Hammock, Devlin, and Collier, 1970, p. 3)"⁴

Stephens, Richard, **Mind Altering Drugs Use, Abuse, and Treatment**, page 87.

Advocates of the therapeutic community approach brand the methadone program a failure by definition, since it does not provide a completely drug-free existence. But along with this loftier goal comes a much greater investment in time, energy, commitment, emotion, and of course money - as well as a much lower rate of rehabilitation. All the patients in the methadone program are ambulatory - they live in the community and can pursue employment and a normal family life. In contrast, members of the therapeutic community live in a drug treatment center for at least several months, and often for as long as several years ; the cost has been estimated at about \$ 25,000 a year for each patient.

Ideally, everyone within the treatment center is a former addict, including the directors. The reasoning is that it is impossible to "con" or lie to an ex-junkie, and that the addict can achieve rapport and identification only if his therapists have had "gut level" experience with addiction. Communication is possible only with a shared universe of meaning. All other, more conventional methods are doomed to failure, largely because of the inability of the non-addict to understand the mentality of the junkie. Such is the ideology of all synanon-type programs. The therapeutic community concept does not work for all addicts ; in fact, it is of limited effectiveness.

One recent evaluation of the success rate of the Daytop Village program found that roughly three-quarters of all addicts accepted into the program left against the advice of the staff ; their fate cannot be known with certainty, but most are probably back on the street living the same life they led before entering. Thus motivation plays a major role in the success of any therapeutic community program, as it does not with methadone. Moreover, studies have shown that addicts who submit themselves to the program, and even more so those who remain in it for any meaningful period of time, are the least involved with drugs, are younger than the average addict, have been addicted for a shorter length of time, have smaller habits, have been arrested fewer times, and are most hopeful of treatment. They are also much more likely to stem from middle class backgrounds (Hammock, Devlin, and Collier 1970). Thus the addicts for whom the therapeutic community approach work represent a limited segment of the addict population. This is not a criticism of the program, only a warning that it is unlikely to work as a total solution. It may very well be the solution for a certain proportion of addicts.⁴

4. Stephens, Richard, *Mind Altering Drugs*, page 103.

REHABILITATION PROGRAMME⁵

No single drug rehabilitation programme should be regarded as a panacea, and that includes methadone maintenance. Making the addict drug-free is a desirable, if somewhat lofty, goal. Research should continue to be directed at finding more effective way of dealing with the problem. The public should not be deluded into thinking that the financial support of a few methadone clinics has solved, or will solve, the heroin problem. And unless a programme is backed up with job placement and psychiatric care, its value will be limited at best. But given these, and even more severe, qualifications, it should be clear that there must be a movement away from reliance - and especially exclusive reliance - on punitive techniques for handling the drug problem. Unless some combination of methadone maintenance (for older, more long-term, and more heavily involved addicts) and the therapeutic community (for younger, less involved addicts) is adequately, meaningfully, and swiftly funded, an increasing amount of human suffering will be generated, more and more deaths will occur, the rate of crimes and violence in the cities will grow apace, and addiction will continue to rise. Anyone seriously proposing more severe penalties as a solution to narcotic addiction is merely contributing to existing problems.⁶

It would be extremely naive to believe that drug addiction will be eliminated completely. Attacking a given problem always involves balancing one value against another. A number of questions must be considered before any single problem can be dealt with. Some questions that interlock with that of effective solutions to the drug problem are : At what cost ? By neglecting what other problem and values ? And according to what definition of a "solution" ?

If law enforcement agents were given virtually unlimited powers to deal with the narcotic traffic, if laws such as the "no knock" bill were passed to make their work easier, and if drastic measures - such as the death penalty for all addicts - were effected, the illegal use of heroin could probably be brought to a virtual halt, but only after the desecration of justice and civil liberties on an unheard-of scale in this country.

Thus, the question is not simply how to deal with the drug problem, but under what conditions we wish to attempt to deal with the problem. As with a serious illness, the most "effective" cure might well destroy the patient.⁷

7. Ibid, page 113.

Dr. Bhim Sain⁸ has discussed in detail the nature and Dimensions of Drinking and Prohibition. Three forewords by Dr. R.C. Jiloha, Associate Professor of Psychiatry, G.B.P.N. Hospital, New Delhi, Khushwant Singh, New Delhi and Satya Paul Narang have gone into details of Alcoholisms and Prohibition Policy of the Government of India and State and Union Territories Governments. Dr. R.C. Jiloha says, "The lodest socially, culturally and religiously accepted drug alcohol has been with us for the last several thousand years but records discussing its disabling effects and it's control date back to Egypt and Masopotamia, and widespread drinking occurred in early Greece and Rome, prompting considerable efforts to enforce moderation.

"It also does appear that the only drug which caused any major social concern was alcohol. Because it is a natural product and it's fermentation occurs commonly in a number of substances throughout the globe. Alcoholic beverages are relatively simple and inexpensive to produce in substantial quantities ; however the use of beer and berry wines predates the recorded history.

"Certainly individuals have abstained from the use of all intoxicants, but the ubiquity of use this drug is so striking that it is difficult not to concur with Andrew



Weil who observes that "It must represent a basic human appetite". Why ? People consume alcohol because of it's effect on brain, as it alters the brain cells and destroys them to block the memory and to dull the senses.

"Alcohol's integral part known as ethanol penetrates the memberances of all cells and disrupts their functioning while other psychoactive drugs target on brain cells. Ethanol enters cell membrances and sabotage parts of brain cell known as neurons Gama Amino Butyric Acid, (GABA) communicates between neurons."⁹

The most recent hooch tragedy, which took a very heavy toll of innocent and poor life of Jahangiripuri Zooggi Jhopari settlars in Delhi is the most fearful reminder of the utter failure of the prohibition policy of the Union Territory Government. A number of such gruesome hooch tragedies have occured in the past in different parts of the country. All of them point to the gross and most neglectful acts on the part of Union, State and Union Territories Administration. It is well known to the highest authorities that there is a very close, hand-in-glove relationship between the Prohibition authorities, excise inspectors and officers and drug control administration including the different directorates supervising the manufacture of different types of

9. Ibid.

pharmaceutical drugs in the country. It was an eye opening fact that lacs of bottles of SURA - and ayurvedic preparation being sold under different brand names such as Mirt Sanjivini, Amar Sura, Yuva liquirs are other various names, marketed by very wide networks of wholesalers, distributors, stockist and ayurvedic stores, pan and biri cigarette, restaurant and hotels, cold drink stalls and even the general stores shall lacs of bottles such SURAS, Asavs, and gootka's and capsules in different measures at very cheap rates have been found to be terribly adulterated with Ethanol or paint thinners take usually vary heavy tolls of human lives. The government in the case of recent hooch tragedy in Delhi and in the past in a large number of Metropolitan cities, big towns and even small townships has been guilty of gross negligence and unpardonable crime. Once the media hue and cry over such tragedy, which take innocent and poor persons as their easy victims, is over the deepest concern and anxiety shown by the administrations results in nothingness. The paltry sums of money are given to the relatives of the victims by the government and sometimes different types of relief is provided by socially awake private/voluntary organisations. But this sad and heart-randng story ends at this point. The unforgivable nexues between penalty,

smuggling and drug trafficking and the administration and the high ups in the society is very often nakedly exposed. But to the misfortune of this country the solemn promises, assurances and declaration made by the so-called guardians of law, custodians of conscience and purveyors of morality and religion swear in the name of God for umpteen times or ultimately zeroed. For such tragic and saddest sagas have been occurring in our society since times immorial and the nation seems to be proud of its glorious and hoary tradition. It is not a most unsavoury commentary on our national character and religion, spiritually ? It is not the blackest slur on the fair name of Bharat ? May God bless our destiny keepers with a little wisdom, honest foresight, unblamish integrity and dedication to pragmatism so that thousands and thousands of our poor countrymen, who usually fall prey to the evil machinations and lust for pelf and power, are saved from the cruel and rapacious teeth of death, despair and dissolution to their surviving kinsmen.

A concentration of GABA in some areas of the brain reduces tension and anxiety and may cause sedation. Valium and Librium both tranquilisers also attach themselves to a certain area of brain with same effect. Ethanol acts upon

GABA sensitive areas and reduces anxiety and tension. Unfortunately our understanding of this phenomenon, and how to deal with it effectively, is at best still severely limited. This ignorance is partly due to our failure to explore fully experiences of different times and places.¹⁰

Dr. Bhim Sain's work serves as a preliminary step in the efforts to acquire and disseminate more knowledge about these experiences which includes as extensive review of those who consume alcohol, romantic and psychological affliction, their management and various avenues of prohibition and social help.

It is apprent that the problem is grave in Indian Subcontinent with its socio-psychological religious and ethnic implications which are very important factors not only in symptom manifestation but also in the outcome and genesis of illness of alcoholism.

He provides a deeper insight about alcohol, its historical perspective, how a reluctant one or two drinks consumer becomes a regular addict and then prey to the devastating effects of physical, social and psychological nature produced by this beverage. He also deals with Social and State attitude, policies and programmes laid

down by the Government regarding prohibition. This kind of information will go a longway to guide those who are working in the area and it is book of general interest for public.

The above views of Dr. R.C. Jiloha contained in his foreword to the book amply support our findings and concluding remarks.

The eminent Generalist and author, Khuswant Singh, appends his foreword to the book where in the examines the Boarda hooch tragedy in the recent past. It is gainful to quote him "The macabre orgy in which 140 people lost their lives after consuming poisonous 'lattha' in Boarda once again raises the issue of how to prevent the recurrence of such tragedies. The temperance lobby always more vociferous and sanctimonious will undoubtedly exploit this incident and press for more regorous enforcement of prohibition laws, dismissal of policemen who failed in their duty to stamp out illicit distillation and deliver sermons on the evils of drinking liquor.

Those who believe that prohibition never succeeds in putting down drink are understandably on the defensive. They need not be so because the tragedy of Baroda proves

their point to the hilt. Gujarat because of its association with Gandhiji and Morarjibhai has been strongly opposed to relaxation of prohibition. It is not a mere coincidence that in recent years more people have died of drinking illicitly distilled poisonous liquor in Gujarat than in any other states of India. It is believed that illicit distillation in Gujarat is a 100-crore per year cottage industry patronised by politicians and policemen. They have had several commissions of enquiry into the business but none of them have had the courage to come out openly and say that prohibition does not and cannot work.

Heavy and habitual drinking is undoubtedly injurious to health ; drinking sensibly is not. As has been observed that drinking beer or wine which have little alcohol is no more bacchanalian than taking enemas. Thomas Jefferson who had considerable experience of the folly of imposing prohibition wrote. "No nation is drunken where wine is cheap ; and more sober where dearness of wine substitutes ardent spirits as the common beverage." The only way to cut down on drunkenness and deaths caused by drinking contaminated brew is to make drinks with low alcoholic content freely and cheaply available to adults.

I am entirely in favour of nationalising the liquor industry (it is enormous profitable) and the state regulating the alcoholic content of beers, wines and spirits.¹¹

Satya Paul in this foreword entitled **DRINKING - THE LEGAL PURVIEW** has discussed the question of liquor, its encienteness and since times in memorial keen concern for it by sociologists, psychologists, criminalologists and the general public as well as the government. He tersely concludes as follows :

"As a result now there is neck to neck fight in mass-media to promote the consumption of nicotine and smoking is no more an offence hence does not find any place in the Indian Penal Code. And also at global level it is not a punishable crime. However, on the health ground to discourage active and passive smoking certain measures are being taken by the states and societies. In some cases, smoking in the offices invites monetary fine and smokers can be compelled to leave non-smoking zones.

"But the case of drinking is entirely different from that of smoking. Like smoking, drinking is also socially accepted and legally permitted but state of

drunkness is not tolerated by the law. After drinking to indulge in undesirable activities such as brawls is punishable offence under the provisions of different Acts."

Under Section 34 of the Police Act any person causing nuisance in public place under influence of alcohol can be hauled up and detained by the Police without warrant. The bailable offence invites the maximum punishment fine of rupees 50 or simple imprisonment for 8 days in default.

In the capital city for example the Delhi Police Act deals with the situation more firmly. The culprits booked under section 112/116 of the act creating nuisance in public place under intoxication can be fined upto Rs. 250/- whereas in Indian Penal Code no specific provision has been provided to deal with such persons. But the persons causing public nuisance under influence of liquor can be booked under section 290 of the I.P.C. which provides ; "whoever commits a public nuisance in any case not otherwise punishable by this Code, shall be punished with fine which may extend to two hundred rupees.

Another provision, section 160 in the I.P.C. also can be used against the persons causing threat to public

peace. The provision states ; two or more persons causing affray in public place can be dealt with but they may not be essentially alcoholics.

Analysis of the provisions of law reveals that the present law has always taken a mind view against those indulging in drinking. Not only this, the law also protects intoxicant against one's will or without knowledge and by reason of intoxication caused thereby, one becomes incapable of knowing the nature of the Act or that he is doing what is either wrong or contrary to law and one commits an act which is criminal, that act comes under the exception provided under section 85 of the I.P.C. Law presumes that such person has committed no offence. Section 86 of the I.P.C. also provides protection to the person who has been administered intoxicant without his knowledge or against his will.¹²

Possession of more than permissible quantity of liquor, illicit distillation and unauthorised storage of alcohol attracts the provisions of section 60 and 63 of the Excise Act. All offences under Excise Act are bailable as per rule 284 of the Excise Rules appended with Excise Act. But the real plight is that a big recovery of alcohol by the Excise and Police official is rarely found. Even if

12. Dorothy E. Dusck Danial A. Girdano, 'Drugs', page 117.

there is a big recovery at initial stages, the case dilutes with the passage of time because bargains are settled from top to bottom because of deep-rooted corruption in the society. This is the general state of affairs however the exceptions cannot be ruled out and every one cannot be labelled as such.

Secondly, there are a good number of alcohol-related cases lying pending for years. Most of these cases show the recovery of one or two bottles ; which may suggest a cooked up case. These cases hardly end in conviction because of lack of public witnesses or the witnesses turn hostile as they are stock witnesses of the police who are not believed by the Courts due to their Character as such which further encourages the hooch king to spreads his net more widely. Police personnel overburdened by their other duties rarely turn up for evidence in such cases. With the result these cases end in acquittal. Again prosecuting agencies often finds it hard to prove a case of illicit distillation due to lack of expertise and training to handle such case.

"It may be recalled here that illicit distillation, trafficking of alcohol and other alcohol related crimes are always from the purview of Narcotic and

Psychotropic Drugs Act 1985 which provides deterrent punishment ; imprisonment of 10 to 30 years and fine of rupees one to three lakhs for production on illegal trade of dangerous drugs like heroin. Obviously it expresses sanction of the Governments to consume alcohol. Under obligation to perform it's duty the states provides adequate facilities to the drinkers, because psychologically drinking in lonely places under fear of police raids results in early loss of self control. At the same time the states have always adopted the measures to educate people to refrain from drinking because education in formative years does more than a law can do."

"The education in family environment - the Sanskars ; the deep rooted attitude to face the struggles in the real life than to seek a very easy escape through alcohol and other drugs can keep a person away from the bottle because life is not something a rosy dream of fairly lands, it is full of thorny paths also. Sometimes there is a trouble within the individual ; with the members of family ; professional trouble and so on. Troubles trouble to trouble at every step of life. One has to learn to face the troubles."

"If attitudes and emotional built up is not strong the troubled individual is free to drown himself deep and deeper in the bottle as he wishes. Welfare states on humanitarian grounds provides psychiatrists to help him to get rid of alcoholism and societies also teach him alternatives to remain sober. All are ready to help him if he chooses to learn how to enjoy sobriety otherwise law is there to punish him for his misbehaviour caused by drunkardness. think the ultimate choice lies with the individual."

WHO TURNS ON AND WHO DOESN'T ?

According to every study that has ever been done on the subject, drug is by far the most commonly tried or used illegal drug in every population, social group, community, and milieu in America. There is no close competitor. In the past few years, as a result of the upsurge in the use of "hard" drugs, it has become fashionable to claim that heroin has "replaced" drug as the most popular drug choice of the young, that drug use is pass's. In actually, drug use far exceeds heroin use ; the two are simply not in the same league. This is true whether we study the college or whites, rich or poor. It has been true in the past, it is true now, and in all probability it will be true five years from now.

Why do young people use drug today ? What are the main motivating forces behind "turning on" ? . t would be totally fallacious to assume that any behaviour as complex as the illegal use of drugs - or even the illegal use of a single drug - can be explained by a one-dimensional theory ; many factors contribute to the use of drugs by an individual or group of individuals. Too often anti-drug propagandists attempt to simplify everything into a pat formula, which typically calls for some sort of solution. "The laws are too lenient" would be one such formula, and "crack down on drug users and supplies" would be its simplistic solution. "Parents are coddling their kids - permissiveness is rampant" is another theme, calling for a heavier parental hand. As usual, the picture is much more complicated. This does not mean that all explanatory efforts are doomed to failure. Certainly there are casual forces at work in drug use. We know in general who is "at risk" to turn on, but why they do so involves a bit of speculation. There are a number of solidly documented generalizations concerning those who try and use drug and hashish. But these generalizations are not necessarily "causes" for its use. They are merely statistical regularities that themselves require explaining. As a start, then, what are some regularities in who uses drug and who does not ?

One regularity that has been empirically supported in a number of different studies in various locales is the generational continuity in drug use. Parents who use legal drugs - cigarettes, alcohol, and prescription drugs such as barbiturates and amphetamines - are more likely to have children who use illegal drugs, marijuana included. This does not mean that every drinking family will raise children who inevitably become junkies ; it means simply that on the whole there will be important statistical differences between drinking families and abstemious families. There will of course be a multitude of exceptions to the rule, but the general pattern appears to be valid and is supported by many studies. Two high school students, Ted Lawrence and Jim elleman, conducted a drug-use survey at their Long island School (Lawrence and elleman 1970). After analyzing almost 1,500 questionnaires, they found that the tendency of students to use drugs such as soft drugs and LSD was significantly correlated with their parent's use of alcohol, cigarettes, and prescription drugs. A series of studies conducted by the Addiction Research Foundation among school children in Toronto (Smart 1970 ; Smart 1971 ; Smart, Fejer and White 1971) corroborated this finding. For instance, striking correlations were found between a monther's use of

tranquilizers and her children's use of illegal drugs. The grade school and high school students whose mothers took tranquilizers every day were almost three times as likely to have tried drug as were the students whose mothers never took tranquilizers - 32 per cent versus 12 per cent. Even stronger correlations were exhibited between parental drug use and a child's use of more potent drugs such as LSD, barbiturates, and opiates.

For instance, only 2 per cent of the children of "never" tranquilizer mothers had tried one of the opiate drugs but 15 per cent of the children of the "daily" mothers had done so. A third study, conducted by a team of public health experts at six sub-urban New Jersey high schools, found that parents who smoked a pack of cigarettes a day were four to five times more likely to have children who had experimented with dangerous drugs such as heroin and methedrine than parents who did not smoke at all (Lavenhar et al. 1971). The correlation was not quite as impressive with drug, but it was significant.

The link between parent's use of drugs and the use of illegal drugs by their children is typically not a direct one. The intermediary is cigarette and alcohol use among young people. Too often we accept the cliché that

liquor is the drug choice of the older, "establishment" generation, and drug of the younger, dissident generation. In fact, the two are only partial competitors, and then usually only at the upper levels of use frequency. Young adults who drink liquor and smoke cigarettes are much more likely to try drug. That is, people who use illegal drugs, especially, are fundamentally the same people who use alcohol and cigarettes - they are just a little further along the same continuum. Thus the use of legal drugs by young people is heavily implicated in the process of turning on to illegal drugs.

What other factors are related - although not necessarily casually - to drug use among young people today ? Interestingly enough, there is a very strong, positive correlation between drug use and social class background. The higher the education, income, and occupational prestige of one's parents, the greater the likelihood of trying and using drug. This correlation has been verified in study after study, in community after community. This finding contradicts the prevailing folk wisdom on the subject - that illegal drug use is a "pathological" phenomenon and grows out of poverty, ignorance, and deprivation.

This generalization between drug use and social position. Young adults who have left the home of their parents are more likely to try drug if they are occupationally successful, earn a better than average income, and are well educated than those whose socio-economic status is below average. This finding has been verified by several Gallup polls ; in one survey college graduates were almost ten times as likely to have tried drug as respondents with less than a high school education (Gallup 1969). It has also been verified in studies conducted by the New York State Narcotic Addiction Control Commission (Glaser and Snow 1969 ; Chambers 1971). In the first of these studies acquaintance with someone who had used drug in the past year (itself highly correlated with one's own use of drug) was positively associated with one's own education.

Political leftism is also statistically associated with drug use. This does not mean that every drug smoker is a radical or that all radicals turn on. It means simply that the two variables are correlated in a positive direction. Moreover, any statement about this correlation does not imply causality ; most likely both liberal politics and drug use are related to a more permissive and

anti-traditional outlook that covers a wide range of attitudes and forms of behaviour. In a study sponsored by the Columbia Broadcasting System of college and non-college youths between the ages of seventeen and twenty-three, a remarkable correlation was found between a particular, self-designated political ideology and acceptance or rejection of the drug prohibition. Of those who called themselves "revolutionary" in political beliefs, 92 per cent said that they "rejected outright" the drug prohibition. As one moved right politically, this figures dropped : 45 per cent for those who called themselves "radical reformers," 32 per cent for the "moderate reformers", 13 per cent for middle-of-the roaders, and 7 per cent for conservative (Columbia Broadcasting System 1969). It would be impossible to deny that political ideology and drug use are strongly associated.

In the famous "Kinsey Reports", the most impressive statistical relationships were found between sexual traditionalism and religious orthodoxy. As we might expect the same correlation holds between religion and drug use that is, there is a negative relationship between

being religiously observant and using drug. People who adhere to formal, organized, religious institutions very rarely use illegal drugs ; people who are estranged from religion are much more likely to try any and all illegal drugs.

Organized religion is not necessarily an absolute shield against involvement with drugs, but the religious are in a statistical sense unlikely to be attracted to drug use. Bruce Johnson's drug use survey also explored this relationship. Of those college students who said that they never attend church, only 26 per cent were complete drug abstainers. The more that a respondent attended church, the less likely he was to use drug. Among those students who attended church once a week or more 77 per cent had never used drug. At the other end of the spectrum, 31 per cent of the "never" church attenders and 4 per cent of the weekly church attenders used drug regularly (Johnson 1972).

We should not look at this relationship in oversimplified terms. Individuals with similar social characteristics or similar life styles tend to associate with one another. Being male or religiously alienated does

not necessarily "cause" drug use. But men, non-religious people, cigarette smokers, and political liberals are more likely to associate with one another. It is having friends who use drug that is the determining factor here, and not simply having some set of "background" characteristics. One's friendship network is the "intervening" variable between one's background and one's pattern of drug use. It is out of specific milieus that drug use grows - making and having friends within those milieus will encourage one to try the drug oneself. Thus background factors do not necessarily lead to drug use directly ; they lead to an association with others who share certain socio-cultural traits, and this association in turn "leads to" drug use. It also leads to a kind of insulation from those who do not smoke drug, which reinforces one's commitment to the use of the drug.

The critics of drug use say that one of the most insidious aspects of the drug scene is the social pressure, that many young people smoke drug because their friends would make them feel like social outcasts if they refused. This is to some extent true, but it is also true of anything related to group values and behaviour. It is

as applicable to attitudes or actions that mainstream society considers "good" as it is to negatively valued behaviour. There is social pressure to wear one's hair short in some groups, and to wear it long in others. A drinker will feel peculiar in some social circles, and an abstainer will feel out of place in others. We find it convenient to label as "insidious" any social pressures that we disapprove of, yet we forget that the social pressures urging us to do what we feel ought to be done operate in precisely the same manner.

The factor of drug-related friendships is thus absolutely crucial in the earliest stages of drug use. The subtle process of acquiring attitudes favourable to drug use consists of having friends and acquaintances who define the experience of use in favourable terms, of having a general ideology that prepares one for initially accepting drug, of realizing that those who are role models actually use drug, and of being intimate with others who use it. All these factors then powerfully conspire to impel the young person in the direction of using drug.

It would be inaccurate to claim that because sociological variables correlate so powerfully with drug use, personality attributes are not related to the process of turning on.

Non-users of drugs, then, tend to be more conventional, more traditional, more oriented toward the adult generation, and more "conservative" than drug users. They are less critical of things as they are, more accepting of the existing order. They believe more firmly in the rule of law, in the correctness of prevailing morality. They are less adventurous, less eager to stray beyond well-defined boundaries. They are more "dependent", if that is understood to mean that they need clear guidelines, a well-drawn blueprint of what is right and wrong. They are less tolerant of ambiguity. They tend to take orders well. They like being part of a team ; they have faith in power hierarchy ; they are "organization men".

ETIOLOGY

A clinically oriented hand-book on drug abuse has little time (and space) to discuss etiologic theories in great depth. There are two excellent books, authoritative and comprehensive, on the "implications of drug abuse/misuse on human body and mind". Those interested in the

intensive and depth study of the effects of drug misuse on human body and mind are advised to refer to them.¹

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1. Ken Liska, *Drugs and the Human Body* (with implications for Society, Macmillan Publishing Co., New York, Third Edition, 1990. Its first edition was published in the year 1991. It had a roaring success. Now it is being published by the Macmillan Publishing Co., New York, Collier Macmillan Chanda, Inc. and Collier Macmillan Publishers, London.

(Some of the material in this book previous appeared in the Author's *The Pharmacis's Guide to the Most Abused and Misused Drugs in America*, Collier Books, Macmillan Publishing Co., 1988).

This new third edition is intended for all persons in interested in examining high use, high abuse drugs in America, and the impact these drugs have on individuals and society. This book can be used in health and drug education classes, public health courses, parent groups and counselor training. It covers every major street and recreational drug, and every prescription and over-the-counter drug that has a history of abuse or misuse. In addition, many of the substances produced in quackery in America (or any country, including India) are discussed. Here is much material in the text, and in the appendices that will prove useful/valuable to health professionals, teachers, counselors, and law enforcement personnel. Nurses, nursing and pre-pharmacy students or para-professionals who need a broad overview of drugs and their implications for society can also use this their profit.

We now turn to this topic (etiology) to demonstrate two things : (i) How difficult etiology is to study, and (ii) How people erroneously tend to state tentative hypotheses as proven facts. As we shall see, a theory that makes sense, is not necessarily true, and a demonstration that factor 'A' is related to factor 'B' does not mean that the former caused the latter.

1. PSYCHOLOGICAL THEORIES

The usually involve comparison of drug abusers and no-drug abusers on performance on psychological tests. The approach at times neglects the possibility that the psychological attributes of drug abuser, who have been abusing drugs heavily for 5-10 years may be the consequence of their life style rather than the original cause. Proponents of psychological theories may also fail to differentiate between studies of why people abuse drugs and why people become drug regulars/addicts.

Richard C. Stephens, Mind Altering Drugs, p. 78-83.

These theories include "tension-reduction hypothesis" which despite the fact that most psychological evidence indicates that drug increases tension) states that drug abusers use drugs in an attempt to decrease their levels of stress. A second set of important theories centres on the premise that people begin to abuse or remain addicts because, drug in some way reinforces or rewards their behaviour through inducing pleasure removing, discomfort enhancing social interaction, and fulfilling the need to feel powerful or, on the other hand, helping them to self-destruct or to abolish unpleasant memories.

Studies of personality characteristics and levels of anxiety in addict and non-addict youngmen at high risk for the future of addiction versus controls, have demonstrated few significant differences between the two groups.

2. SOCIO-CULTURAL THEORIES

A second approach centres on socio-cultural theories, which use observations of similarities and differences between cultural groups and sub-groups as they relate to drug-taking practices. The major importance of

this approach is heuristic and no factors that are purported to be important in the development of addiction or dependency in one culture have been shown to generalize to more other cultures. An example would be the statements that religious have low rates of alcoholism because sectarian children are introduced to drugs within the home setting and drug is used as part of religious ceremonies a theory that ignores the very high rate of drug-abuse among the Sikhs or Hindus, Muslims, Parsees/SCs/STs for whom both factors also operate.

3. BIOLOGICAL THEORIES

A series of biological theories is found in the literature including the possibility that drug dependents are seeking relief from an inmate hypoglycemia that they have allergies to drug or the congeners found in alcoholic beverages, or that a differential brain responsiveness to alcohol and necotene exists in regulars addicts. Once again, it has not been established whether the psychological abnormalities of drug dependents were the initial cause of the heavy drug-abuse or resulted from a life-style of relatively poor nutrition, poor housing and environmental high stress, and high doses of ethanol.

One theory, which has had a great impact in the field by developing a focus on the chemical changes in nervous system functioning that result that drug may produce a morphine like substance in the brains of certain individuals that may subsequently be responsible for the level of addiction. These substances (tetraphy condensation of acetaldehyde and brain neurotransmitters such as dopamine or serotonin in the test tube.

Such observations have opened an important area of research, but it is not likely that levels of these materials capable of functioning as false neurotransmitters are actually formed in the brain after heavy drug abuse. These findings may tie into genetic propensity toward drug addiction, drug dependents, exalcoholics have been shown to have higher levels of acetaldehyde after drinking and it is possible that similar findings may occur in individuals at higher risk for the future development of alcoholism. At present, these findings are only of the theoretical interest and will require much more research work before their validity can be established.

4. GENETIC APPROACHES

A series of studies has established the probable importance of genetic factors in the genesis of primary drug addiction. This disorder has been shown to run strongly within the families, and rate of concordance (or sameness).

In fact, genetic approach forms part of physiological level perspectives¹ : Stephens Richard C. has discussed under the umbrella of physiological level perspectives : Neurological actions, The Metabolic Deviciency Theory, Well's theory of the natural mind.

In fact, a critical evaluation of physiological level approach and genetic approach reveals their deficiency to the extent that they are unable to explain the drug abuse with sufficient success. Another set of important theories is referred to as Psychological Level Theories which include the Psychanalytic Approach, The Addictive Personality, The Medical Model of Drug Abuse, The Learning Theory of Drug Abuse, The Social Structure Prospective. However, none of them is found to be competent in explaining satisfactorily the problem of Drug Abuse.

Next follows Social Psychological Perspective which encompasses : Sociologically Oriented Social psychologists, Kaplan's Theory of Drug use. This perspective is also defective in certain important respect.

Sociologist and Anthropologists have subscribed to the sub-cultural approach. Under this leading banner follow The Socio-cultural Approach, The Socio-cultural Approach and use of Drugs other than Heroin.

What are the criticisms of this approach ? There are those, citing the many psychometric and clinical studies of drug users, who do not believe it has much empirical validity. As I have tried to point out, such data are flawed, at least to some extent. Others simply cannot believe that "normal" people would use drugs such as heroin. (An interesting exercise is to ask such individuals how they feel about cigarette smokers ; would "normal" people become addicted to a proven dangerous, and often fatal drug such as tobacco ?) Many simply accept the fact that drug abusers have to have something wrong with them. Such people probably will not accept the socio-cultural viewpoint proposed here.

Other criticisms of the perspective include the fact that it comes close to being tautological. Indeed, this is a valid point and must be examined carefully. One cannot say that people use drugs because they belong to a drug sub-culture and then turn around and "prove" the theory by demonstrating the existence of the sub-culture by pointing to the fact that its members use drugs. However, if role is defined in terms of expectations rather than behaviour, this tautological trap can be avoided. The sub-culture theory also cannot adequately describe why some who are exposed to the sub-culture become members and others do not.

INTEGRATED MODELS OF DRUG ABUSE

Thus far we have looked at theories that have emphasized one level of conceptualization, whether individual, group, or societal. Some researchers have adopted the viewpoint that these levels need to be integrated in an effort to develop a more complete theory of psychoactive drug use. Two such attempts at generating integrated models have been made recently : the explanatory models of adolescent drug use developed by Elliot and his colleagues (1985) and by the Jessors (1977). Both of the models are presented in monographs ; space limitations preclude more than a general outline here.

ELLIOTT'S INTEGRATED THEORY

Delbert Elliott and his colleagues draw heavily upon several theoretical traditions in sociology. Two of these perspectives - social learning theory and strain theory (Merton) were discussed earlier in this chapter. The third perspective upon which he draws is social control theory. Social control theory basically asserts that individuals are constrained against committing deviant acts because of their bonding (or emotional attachment) to non-deviant others. According to Elliott, there are also positive motivations to commit deviance that emanate from bonding and commitment to deviant others. Elliott develops a sophisticated casual model combining the following clusters of independent variables :-

1. Socio-cultural environment, consisting of social dis-organization and the availability of illegitimate learning structures. For example, a child might grow up in a neighbourhood characterized by poverty and social dis-organization and where delinquent and drug-using groups are easily accessible.

2. Primary environments, which is composed of the kinds of early socialization experiences to which the child is exposed. In one environment children are effectively socialized to bond to conventional groups and commit or ineffective early socialization are more at risk of bonding to deviant groups and of committing deviant behaviour.
3. Conventional bonding. Elliott maintains that people vary the degree of conventional bonding they undergo. Some are fully committed to non-deviant behaviour and have strong internal and external controls against deviant behaviour. Others have weak ties to non-deviant groups and norms and thus are more likely to engage in deviant behaviour.
4. Deviant bonding. Some individuals experience a very positive motivation toward deviance and receive rewards from committing deviant acts. Deviant bonding, or an integration with and commitment to deviant others, results.
5. Strain. As can be seen in the earlier discussion of Merton's work, strain results from the individuals's feeling that he or she is blocked from access to opportunities to achieve personal success goals.

Elliott and his associates have combined these variables into a causal model of delinquency and drug use :

"This etiological sequence identifies strain, inadequate socialization, and social disorganization as the primary causes of weak bonding to conventional groups, activities, and norms. It further specifies that weak conventional bonding and/or high levels of strain lead some youths to seek out and become bonded to peer groups that provide positive reinforcements for and modeling of delinquent behaviour ; i.e., delinquent groups. And finally, it specifies that bonding to delinquent groups, when comined with weak bonding to conventional groups and norms, leads to a high probability of involvement in delinquent behaviour (1985 : 65).

After empirical tests of the model, Elliott and his associates conclude that the integrated model is highly explanatory, especially of drug use.

THE JESSOR'S THEORY OF DRUG ABUSE

Richard and Shirley Jessor have proposed a fairly complex, integrated social psychological theory of adolescent drug use (and other deviant behaviour). This explanation, which sees personality as the main theoretical variable, is called problem behaviour theory.

The Jessors argue that problem behaviour, as well as conforming behaviour, comes about from an interaction of the child's personality with the environment. The personality system is composed of a number of specific variables that belong to three component structures - a motivational - instigation structure, a personal belief structure and a personal control structure. The motivational instigation structure is represented by the relative value that the adolescent puts on academic achievement, independence, and peer affection. The personal belief structure includes variables that either encourage or discourage youth from engaging in problem behaviour. Included here are social criticism, alienation, self-esteem, and internal-external locus of control (e.g., whether one believes one's actions are under one's own control or are due to the actions of others). Finally, there are the variables in the personal control structure that militate against deviant behaviour. These include one's attitudinal tolerance of deviance, religiosity, and the discrepancy between positive and negative reasons for engaging in behaviours such as drug use, premarital sexual intercourse or drinking.

The main characteristics of proneness to problem behaviour in the personality system include lower value on academic achievements ; greater social criticism and alienation ; lower self-esteem and an orientation toward an external locus of control ; greater attitudinal tolerance of deviance ; lesser religiosity ; and more importance attached to the positive, relative to the negative, functions of problem by Timothy Leary in 1966. One of more durable cult is the Church of Awakening founded by two physicians John and Louisa Aiken in Mexico during 1958. In 1970 it had a country wide membership of 4000. The members of this cult administered both Peyote and Mescaline sacramentally and with complete safety until prohibited by law.

SOCIAL PERCEPTION OF DRUG ABUSERS¹

Our earlier communication reported on 14 long-term drug abusers on their psychological and cognitive functions against non-users drawn from the general respondents (300 sampled hostellers) to which the users belonged. The study did not reveal any significant difference between the two groups.

1. We took the cue from R. Roy, "Social Perception of Cannabis use" in

To confirm these observations it was decided to interview the close relative of the regulars and addicts (14 in our case) to look for any perceptible decline, in social functioning among the 14 users to them.

Poor performance in examinations may indicate intellectual decline, but deterioration of cognitive functions is likely to accompany a decline in social functioning. The last 14 persons among the drug users (of the 300 sampled respondents) as assessed by their low performance in examinations, were chosen for the present intensive study. One of the close family members (or close friends/relatives) was interviewed to elicit further information. A formal permission for the interview was obtained from all the 14 users.

The respondents were asked the following questions in the following order :-

1. Duration of contact with the user and the relationship with the respondent.
2. Any change as observed by a respondent in the personality of the user in the last five years.

3. The following areas were covered :
 - (a) Level of ambition and aspiration.
 - (b) Competitiveness
 - (c) Unconventional attitude.
 - (d) Level of intelligence.
 - (e) Level of honesty.
 - (f) Religious/spiritual inclination.
 - (g) Any other significant information.
4. Subject's work history and productivity level.
5. Subject's involvement in quarrels with others resulting in physical injury or involvement with the police/law.
6. Whether the subject was a drug user to the best of respondent's knowledge.
7. The respondents were asked about their attitude towards drug use and the choice between alcohol and cigarettes (nicotine containing substances) or between the drug used by his friend relation/kin etc. (the regular or addict) as intoxicant agents.

All the respondents, fortunately for us, agreed easily to be interviewed. Of course, there was some

hesitation showed by three of them in respect of some penetrating queries relating the loss of social prestige or social respectability of regulars/addicts. It is but natural for humans to conceal/distort/misrepresent things on such sensitive matters for one likes to confess slight or damage done to his/her relatives/friend's social position. However, I could with some initial difficulty was successful in establishing a close rapport with the respondents and with the help of suggesting/leading questions or sometimes by using innuendoes or insinuation in general and draw/elicit relevant information on the problem.

Among our respondents were both males and females. They full cooperated with me. They were assured anonymity and were freely communicative.

TABLE 8.1

SOCIAL PERCEPTION OF DRUG ABUSERS BY THEIR PARENTS/SIBLINGS/RELATIONS BY COLLEGE/UNIVERSITY AUTHORITIES

S.No.	Question About	DURATION										DEPENDENTS										Grand Total				
		Minimum 3 Years					Maximum 5 Years					Regulars					Addicts									
		M		F		T	M		F		T	M		F		T	M		F		T	M		F		
		M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	
1.	<u>RELATIONSHIP</u>																									
a)	Friends																									
b)	Parents																									
c)	Siblings																									
d)	Relatives																									
e)	Hotel Warden																									
f)	Hotel Prefect																									

		* MORE		* LESS		** NO CHANGE			
		M	F	T	M	F	T	M	F
2. CONGITIVE FUNCTION SOCIAL FUNCTION									
a)	Ambition/Aspiration	10 (19.6)	3 (23.0)	13 (25.4)	8 (21.8)	4 (30.7)	12 (23.5)	38 (74.5)	13 (25.5)
b)	Competiveness	11 (21.5)	4 (30.7)	15 (29.4)	12 (31.6)	3 (23.0)	15 (27.4)	35 (68.6)	16 (31.4)
c)	Unconventional behaviour	7 (13.7)	3 (23.0)	10 (19.6)	9 (23.7)	2 (15.4)	11 (21.5)	37 (72.5)	14 (27.50)
d)	Intelligence	6 (11.7)	1 (7.7)	7 (13.7)	6 (15.70)	2 (15.4)	8 (15.7)	34 (66.6)	17 (33.4)
e)	Honesty	1 (2.0)	1 (7.7)	2 (5.8)	2 (2.6)	1 (7.7)	3 (5.8)	33 (64.7)	18 (35.3)
f)	Religious/Spiritual	1 (2.0)	1 (7.7)	2 (5.8)	2 (2.6)	1 (7.7)	3 (5.8)	30 (58.8)	21 (41.2)

		INCREASED EFFICIENCY		DECREASED EFFICIENCY		UNCHANGED		TOTAL	
		M	F	M	F	M	F	M	F
3.	Productivity	13 (26.4)	4 (23.6)	9 (69.0)	4 (31.0)	16 (76.0)	5 (24.0)	38	13
		RISE		FALL		NO CHANGE			
4.	Social Position	10+5 (59.0)	2+0 (12.0)	8+2 (19.6)	2+0 (39.2)	20+2 (43.1)	0+0 (0.0)	38 (74.5)	13 (25.5)
								51 (100.0)	

* Rating was entirely arbitrary and was dependent upon the respondents subjective evaluation on the various parameters.

** Males and females have not been separated.

We contacted drug users parents, friends, siblings, relatives and hostel/college/university authorities to know about their perception of the drug abusers. The drug-abusers were divided into two groups : who had upto three years contact with the above mentioned parties, and those who had contacts with them upto five years. 36 and 15 drug regulars/addicts had the first type of contact and upto five years contact respectively with parents. 33 and 5 drug abusers had the similar duration contact with friends, 28 and 10 and 10 and 3 respectively with siblings and 25 and 13 and 13 respectively with relatives, 25 and 13 and 9 and 4 with the hostel wardens and 32 and 6 and 13 respectively had close contacts with the hostel prefects. All these persons (whose perceptions about drug abusers were to elicited) were asked confidentially the relevant questions. Their perceptions about drug abusers were elicite on the following parameters : cognitive functions and social function ; productivity (academic efficiency or performance and achievement in the field of extra-co/curricular activities had social position. The responses were quite dis-similar. Whereas in the case of social function and cognitive functions 25.4 per cent told .that drug abusers were

capable of realising their ambition/aspiration - upto 3 years contact cases, and this capability increased by drug abusers, 23.5 per cent said that the drug abusers were seen with reduced capability to realise them. The competitiveness in case of 29.4 per cent (upto 3 years contact) and 27.4 per cent (upto 5 years contact) was seen to have decreased. No change was indicated in case of 74.5 and 25.5 (a) ; 68.6 and 31.4 (b) ; 72.5 and 27.5 (c) ; 66.6 and 33.4 (d) ; 64.7 and 35.3 (e) ; & 58.8 and 41.2 (f) respectively.

On the parameter of productivity, increase in efficiency was indicated in case 76.4 and 23.6 ; decrease in efficiency in case of 69.0 and 31.0 and no change in efficiency was perceived in case of 76 and 24 per cent respectively.

Similarly, on the parameter of social position, rise was perceived in 59 and 12, fall in 19.6 and 39.2 and no change in 43.0 only respectively.

None of the respondents refused to be interviewed in our case. They were assured anonymity and were freely communicative.

1. In the above mentioned survey, four respondents gave history of violent behaviour on the part of the subject resulting in physical injury. None of the respondents had been in police custody or faced charges before a court.

While in our case, 10 subjects were alleged to have indulged in violent behaviour and 3 of them faced police batons and custody and 2 of them were landed in a court of law.

2. In the said study by Ray, six of the respondents knew that the respective subject inquired about were regular users of the drug. Two of them said that the respective subjects were occasional users. One told that the subject had not tried any kind of intoxicating drug to the best of his/her knowledge.

In our case, 15 respondents knew that the respective subjects inquired about were regular users ; twenty of them said that the respective subject were occasional users, 5 said the subject had not tried any intoxicant.

3. Eight of the respondents (in Ray's study) did not approve of any drug use ; seven said that alcohol/nicotine was less preferable to hard intoxicants ; they were tolerant cannabis.

In our study, 30 said that they approved of mild intoxicant to hard intoxicants or narcotics. 14 said that alcohol/nicotine use was smeared with social respectability. They were not harmful, or if harmful, the effect was noticed only when used high doses. None of the respondents approved use of the hard drug or narcotics. In fact, they admitted that hard drug was makes one.

RESEARCH IN DRUG ABUSE

PSYCHOTROPIC SUBSTANCES IN RETROSPECT

Give me a bowl of wine -

In this I bury all unkindness

(Julius Caesar)

The existing literature suggests that researches of diverse dimensions have been conducted by various disciplines of human sciences on psychotropic substances and their usages. in the following pages a brief account

of such researches undertaken are evaluated and discussed in the light of the present study. Further, at the outset we would like to mention that the evaluation of only those literature have been attempted which deal with hemp and opium since the main focus of our study in their usages in various forms among human groups. But their usages in various forms among human groups. But reference will be made of the studies conducted other than the mentioned psychotropic substances if the need will be felt to treat the subject on a wider perspective.

The old world had known psychotropic substances, drugs and plants for centuries before it surrendered its knowledge to Europe. Consequently, the so-called 'dope literature' is quite recent. The earliest recorded literature is of Thomas D. Quincey (1821). His famous "Confessions of an English Opium Eater" founded the genere of writings since 1821 and onwards. Though the mention of the effects of such psychotropic substances have been traced in many writings of not only the researchers of various disciplines but also literary works of established authors. As for example, the recent researches into Levi Carroll's 'Alice in Wonderland' has established that the author had conceived one of the characters of the Caterpillar with his hukka as a drug addict.

Further, the most talked about works of Aldous Huxley (1954, 1975) "The Doors of Perception" and "Moksha" have lucid details about his experiments with mescaline derived from Peyote cactus. The earlier studies conducted to document the indigenous health practices brought forth the fact that the psychotropic substances have been used not only for medicinal purposes but also for performing certain cults prevalent in various societies. Efron (1967) reviewed the ethnopharmacologic search for psychotropic drugs including materials on various cults. Wasson (1957, 1968) traced the use of mushrooms as psychotropic substances in the history of population living in Russia Persia. Further, with special reference to Indian context we find the mention of the psychotropic substances like opium and Indian hemp by some of the practising doctors in pharmacopia India. The Bengal Dispensatory (1842) which gave a detailed account of the preparaiton of opium in Calcutta and results of the investigations for medicinal properties of Cannabis conducted by European physicians in India. The medical practitioners like O'Shaughnessy (c.f. Dymock et. al., 1842) tried Opium more or less with success in various diseases like titanus, hydrophobia, rheumatism, convulsions in children and cholera. Dr. J.E.T. Aitchison (c.f. Dymock et. al., 1842) stated that

oil of the seeds of Cannabis was in use in Kashmir as a liniment for rheumatic pains. Further, tincture of this plant was used as a perfect anaesthetic agent. Some of the medicinal uses of Cannabis and Opium are summed up as follows :

1. As a sedative ;
2. Uterine contraction in case of uterine haemmoerage
3. To increase the labour pains ;
4. To relieve various muscular pains ;
5. To restore mental faculties in cases of mental disorders ;
6. During teething of children ; and
7. To cure epileptic convulsions.

The literature on pharmacological researches revealed the existence of certain cults in the societies of America. The native American Church and Bwiti cult have been studied more thoroughly than any other pharmacological cult. The American Church cult developed into syncretic religion, differing from tribe to tribe in minor details and in degree of assimilation of Christian elements. In this particular cult the Peyote - psychotropic drug, occupies a high ritual position. Peyote is highly venerated and is equated with a 'gift of God'. sometimes with God.

This psychotropic drug is looked on partly as the possessor of magical qualities like protection, healing, revealer of hidden knowledge and partly as a guide that motivates, strenghtens and guides the followers in various tribes. There is an estimated figure of three lakh members of this cult. Since these cults use various psychotropic drugs, they have received harrasement and unsympathetic criticism by a majority of Christian Missionaries. Consequently, the history of such communities are brief and the existing communities have moved to rural or even to forecast areas. This statement may be substantiated with the example of League.

SOLUTION TO THE DRUG PROBLEM

Let us begin with the question : "What is the solution to the drug problem". The anxious public asks. Official repeat the question and found research projects that hint at an answer. Actually, the deeper and more specific meaning of this question is : How can we get people to stop using certain drugs with a minimum of economic cost, and without disrupting existing social institutions and arrangements ? The answer to this question is that there is at present no possible solution

to the drug problem. There is no program in effect or under discussion that offers any hope whatsoever of a "solution" asking for the solution to the drug problem is a little like asking for the solution to the accident problem the food problem, the sex problem, or the violence problem. There are simply certain forms of behaviour that will produce, or will be associated with, the use of drugs. The use of mind-altering drugs is linked to broader social forces and influences that are not going to change very much, at least during this century. There will probably always be a pool of "drug-prone" individuals. of course, if some master visionist a hundred years ago had been able to predict future drug discoveries and use trends, it might have been possible to develop alternatives to psychoactive drugs ; but history is behind us, and nothing can undo the past and present forces that have produced the existing situation. "This long quoad is from the famous book by eminent Prof. Good Erich" "Drugs in American Society".¹ We were oblized to resort to this strip because there is great hue and cray in American Society, the most advanced western civilization, facing real drug menace in the form of addiction of anger generation to Marijuana (or Hashish or Ganja) and others

numerous drugs, manufactured from natural as well as synthetic elements, has been the subject of wildest possible enquiry and discussions among all shades of Researchers including sociologist and social workers cum social engineers.

Erich Good says further about the social control of drugs most elaborately we are herewith giving a brief summary of his concluding part of the ever mentioned book. This is being done because it is most relevant for us in India which is still not facing the so-called drug deluge or the drug epidemic.

Efforts at the social control of drugs - such as reducing the supply, increasing the social or economic cost, and instituting stiffer penalties for use - will often have some impact ; they may produce a temporary reduction in the number of users. But typically they result in far more serious secondary social maladies. Efforts at social control will never by more substantial than a minor "finagle factor". The only real impact on drug use will come about as a consequence of drastic and massive social change, on a scale that will destroy American society as we know it today. This may be positive

or detrimental, depending on one's point of view. One solution on this scale would be to execute anyone suspected of using an illegal drug, without trial or evidence, this is clearly impossible and unrealistic (not to mention barbaric), but it would probably do the trick after something like a quarter of the American population had been murdered. A second solution would be to undertake a massive program to totally restructure the society to insure that all Americans live a life they consider meaningful. This would, at the very least, involve the total elimination of poverty, racial discrimination, warfare, a sterile and alienative educational system, boring employment, and a wretched public bureaucracy. However, this too is impossible, because much of the public as well as those in positions of power, either does not see these issues as the crushing problems that many compulsive drug users do or is not willing to pay the price to do anything about them. Moreover, this solution might reduce alcoholism and narcotic addiction but not the recreational use of psychoactive drugs, such as weekend marijuana smoking.²

In short, I do not feel that any of the solutions that would make a meaningful dent in the addiction problem are in the ball park. The only realistic approach to the drug problem is to develop methods, not to eliminate drug use or even to drastically reduce it, but to live with it and to make sure that drug users do not seriously harm themselves and others. Drug use is here to stay, and the only way to eliminate illegal drug use is to eliminate the laws outlawing the use of certain drugs. Addiction is a fact of American life. Heavy, frequent, compulsive, chronic drug use is also here to stay. Something might be done about the use of certain drugs - it might be realistic to ask, not too restrictively, which drugs will be available to the American public or steps might be taken to reduce the relative size of the addict population - for example, the nation's 9 million alcoholics or its 2,50,000 heroin addicts - but a drastic or even substantial reduction is not feasible. A large number of chronic users of various drugs will probably always be with us, at least for the next two or three generations. Thus the issue we should be exploring is : Given a population of heavy drug users in the society, how can we minimize harm to everyone involved ?³

OUR OWN PERSPECTIVEull

It should be obvious at this point that we, too, feel that the phenomenon of drug abuse is extremely complex. Although we certainly do not have a solution, we have reached some general conclusions about drug user and ways of dealing with it. We believe are supported by the facts currently known :

1. We must accept the fact that drug use will always be with us. For millenia men and women have used some kind of substance to alter their consciousness. Whether this is, as well maintains, an inherent human trait may never be known. However, what is known is that there has probably never been a period of time in human history when we did not at least occasionally seek some non-normal state of consciousness. Total abstinence, either as a general societal goal or as an individual treatment goal, for many abusers

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1. This perspective has evolved out of numerous studies on drug abuse as well as our approach to the problem under enquiry.

is unattainable. i agree with Goode when he concludes that "the only realistic approach to the drug problem is to develop methods, not to eliminate drug use or even to drastically reduce it, but to live with it and to make sure that drug users do not seriously harm themselves and others".

2. For many drug use is an enjoyable activity. This "fun" aspect is rarely alluded to in the professional literature. Yet it is the rare individual who does not like to "let his or her hair down". Once in a while, and even individuals may seek the release from inhibitions provided by many psychoactive substance. This is another reason why drug use will always be with us.
3. Many of these substances, when used properly, occasionally, and in moderate doses, probably are not harmful. This statement assumes that the user obtains drugs that are free of harmful additives, an assumption often unmet with street drugs. Certainly many illegal psychoactive substances would appear to be no more harmful than alcohol and tobacco, and in some instances are probably less harmful.

4. Many of the serious health consequences that accompany psychoactive drug use are due to the fact that the substance are not used properly, occasionally, or in appropriate dosages. I guess that at least some of this misuse is due to a lack of knowledge about how to use drugs properly, clearly such a situation presents a clarion call for appropriate education.
5. Accordingly, there is a need to develop a strategy whereby persons can learn how to use drugs safely and reasonably. Whether such education is to be offered in the school (as adjuncts to health classes) or outside of the school should probably be decided by each individual community. The point is that much information is provided to students about the dangers of drug use, but I know of little information that is available to them about how to protect themselves should they decide to experiment with drugs.

This is not to say current educational prevention efforts should be halted. I believe, alongwith most Americans, that regular and heavy use of

drugs is not a desirable state. Therefore, there is a continuing need for both youth and the public in general to be educated about the dangers of drugs. Youth also need to know how to cope with emotional stress and how to resist peer pressure to use drugs (topics of central concern in many prevention programme today). New and innovative types of programs, such as teaching students how to change their state of consciousness (as proposed by Weil, 1972), also need to be offered to students.

6. Society must cope with the problem of adulterated drugs in the street marketplace. Possibly more clinics need to be established to test the purity of drugs. Users could send samples to these clinics to make certain the drugs are safe.
7. We need to recognize the fact that psychoactive drugs are vastly different from one another. They cannot be lumped into one category, as so often happens both in the law and in the mind of the general public. The way to deal with these drugs is not as a totality, but rather by considering each type of psychoactive substance separately.

Clearly marijuana appears to be a much more benign drug than, say, PCP. Heroin, in some ways, may be less dangerous than barbiturates (or possibly even tobacco). We need to develop legal policies that are more rationally based and that take into account the different physiological, psychological and societal impacts of use of these substances.

As a result of viewing drug use in this new, more complex light, we might decide to deal with use of different drugs differently. For instance, we might legalize or at least decriminalize marijuana. We might establish a heroin maintenance program on an experimental basis. We might even decide to penalize more heavily certain substances such as PCP. Whatever position we take, we need to do so on the basis of fact and logic rather than raw emotion and half-truths.

8. As a society we need to accept the fact that there will always be certain people who will be severe drug abusers. As we have seen, drug use is not simply the act of a desperate person seeking escape from an unbearable situation. Drug use must

be understood in much larger socio-cultural context in which it is found. The social structural conditions in which some drug abuse, such as heroin use, occurs will be with us for a long time. Therefore, we should probably expect that for an equally long time we will have drug abuse with us.

9. We need to continue to provide treatment programs for those who no longer wish to use drugs. I am not sanguine about the effects of treatment for those who do not wish to give up their drug use, but the chances of success are greater for those who are truly motivated to stop. We need to continue to offer a variety of programs to such individuals.
10. Finally, we need to develop strategies on rationality and knowledge. Knowledge is generated by research, and we need to continue to conduct and support such research efforts. If this book, which has drawn upon existing research, contributed to furthering readers' knowledge about psychoactive drugs, how they are used, and why they are used, then it will have achieved its goals.

BIBLIOGRAPHY

BIBLIOGRAPHY

1. Abdull, A.P. Badway, "Alcohol and Alcoholism Vol. 18 No. 4, New York, 1983".
2. Advani, Sharma, Sundram & Mohan, "Alcohol Abuse in Rural Areas of Ajmer District", paper in Mohan (ed) "Current Research in Drug Abuse in India", op. cit., pp. 169-174.
3. Advisory Committee on Alcoholism (1977), "Report on Prevention, London.
4. Asthana, S.N. (1962), "The cultivation of the opium poppy in India. Bulletin on Narcotics, 6 (3), 4".
5. Ahuja, Ram (1982), "Sociology of youth subculture, Rawat Publications, Jaipur, p. 23.
6. Banerjee, R.W. (1968), Prevalence of habit forming drug and smoking the college students. A survey Indian Medical Journal.
7. Bean Philip, The Social Control of Drug.
8. Bhargava, Dr. D.K., "A drink too many, the evening news, New Delhi, 10th December, 1987.
9. Bhim Sain, "Drug Danger and Social Behaviour New Challenges, Sharda Prakashan, New Delhi, 1988".

10. Bhim Sain, "Drug abuse runs the economy too, The Evening News (The Hindustan Times), New Delhi, 21st August, 1985".
11. Bhim Sain, "Drug addiction in India, The search light, Patna, 10th May, 1985".
12. Banerjee, R.N. (1963), "Prevalence of Habit forming Drugs and Smoking Among the college students : A Survey" Indian Medical Journal, 57, 194.
13. Bill W., Alcohol's Anonymous comes of age, New York, N.Y., Harper & Row, 1957.
14. Bwen M.M., "The elderly and drugs problem, over vien and programme strategy. Public, Health Report, N.Y., 1977.
15. Blum, R.H. & Associates (1969), "Students and drugs, Vol. II, San Francisco, Jossey Boss-I.
16. Brown K.E. & Campbell A.H. (1961), Tobacco, Alcohol and Tuberculosis, British Journal of Diseases of the Chest, 55, 150.
17. Cohen, S. (1970), "Control of drug abuse, Federal Probation, 34 (1) 32.
18. Chopra, I.C. & Chopra, R.N. (1965), "Drug addiction with special reference to India, New Delhi, C.S.I.R."

19. Carcy, J.T. (1968), "The College drug science, Englewood Cliffs, Prentice Hall".
20. Chitnis, S. (1974), "Drug abuse on college campus", Tata Institute of Social Sciences, Bombay.
21. Danial Glaser, Crime in our changing society.
22. Dorothy E. Dusek/Daniel, A. Girdano, Drugs : A Factual Account. Fourth Edition, 1986.
23. Dube, K.C., Kumar, A., Kumar, N., & Gupta, S.P. (1978), "Prevalence and Pattern of drug use amongst college students. Acta Psychiatrica & Condingviea, 57, 336."
24. Dube, K.C., Kumar A., Kumar, N. & Gupta, S.P. (1977), "Drug abuse among college students, An Interim report. Bulletin on Narcotics, 29 (1), 47".
25. Dube, K.C. (1972), "Drug abuse in northern India observation concerning Delhi - Agra region. Bulletin on Narcotics, 24, 2.
26. D. Mohan & H.S. Sethi, "Current Research in Drug abuse in India, (1981)"
27. Desai Nimesh & Others, "Retrospective Analysis of Alcohol withdrawal states. Paper in 38th IPS conference, "Abstracts", p. 84.

28. Desousa & Desousa, "Presently patterns of Heroin Dependents", paper in 38th IPS conference, Jaipur, "Abstracts", p. 88.
29. Desousa & Desousa, "Monitoring Beta - Edorphin levels in Heroin Dependence", paper in 38th IPS "Abstracts", p. 86.
30. Desousa & Desousa, Papers on "Proxylon Dependence - An Analysis of 100 patients" and "Fortwin Dependence" prescribed in 38th IPS conference "Abstracts", p. 75 and 91.
31. Deb, P.C. & Jindal, R.B. (1974), "Drinking in Rural Area : A study of selected villages of Punjab", Punjab Agricultural University, Ludhiana.
32. Dube, K.C. (1972), "Drug abuse in northern India observations concerning Delhi - Agra region" in Bulletin on Narcotics", 24, 2.
33. Dayal, J. (1972), "Drug abuse and youth ;p Inter Disciplinary Seminar, Directorate of Social Welfare, New Delhi.
34. Einstein, S. & Allen, S. (1972), "Students drug surveys, Farmingdab : Baywood.
35. Einagar, M.N., Maitra P. & Rao, M.N. (1971), "Mental health in on India Rural community", British Journal of Psychiatry, 118, 499.

36. Fugua, P. (1978), "Drug abuse : Investigation and control, p. 4, 8-9, 12, New York : Mc Graw Hill".
37. Gammage, Allen Z., Alcoholism, Skid and the Police - Sprinoified ill Charles C. Thomoes, 1972.
38. Glatt, M.M. (1971), "Abuse of Alcohol".
39. Goodwin, D. (1976), "Is Alcoholism Hereditary ?" New York.
40. Glatt, M.M. (1975), "Alcoholism - A Social Disease, London.
41. Gurmeet Singh & Brijlal (1978), quoted by D. Mohan in "A study of prevalence and pattern of drug abuse in rural Punjab" in current research in Drug Abuse in India".
42. Gangrade, K.D. & Gupta, K., "Drug abuse among Industrial workers" in Mohan's (ed) "Current Research in Drug abuse in India".
43. Hore, B. (1976), "Alcohol Dependence, London".
44. Hawker, A. (ed) (1976), "Alcohol use and abuse, London Medical Council on Alcoholism.
45. Jones, Kenneth, Drugs, Alcohol and Tobacco, San Francisco, Cavin Canfield Press, 1970.

46. Jellinak, E.M. (1960), "The Disease Concept of Alcoholism New Brunswick, N.J. Hill House Press (A classic work by the founder of modern alcoholism studies)".
47. Jain, S., Shetty, T., Ray, R., "Erythrocyte membrane lipids in Alcohol Dependence", paper in 38th IPS conference, Jaipur, "Abstracts", p. 75.
48. Jiloha, R.C. & Munjal G.C., "Adolescent Heroin Smokers of Delhi", papers in 38th IPS conference, Jaipur, "Abstracts", p. 90.
49. Jha, B.K., Satyawati Devi & Gupta, A.K., "A psychiatric study of 193 smack addicts", paper in 38th IPSC, "Abstracts", p. 85.
50. Kocher, D.S., Sundram, K., Ray, R., & Mohan, D. (1978), "A prospective study of non-medical use of drugs in psychiatric patients. Abstract of the XXXth Annual Conference of the Indian Psychiatric Society, New Delhi, A. 1, 1. M.S.
51. Kessel, N. and Walton, H. (1965), "Alcoholism Hermonds Worth : Penguin".
52. Khan, M.Z. (1978), "Social Correlates of drug use among college students in Jabalpur town (Mimeographed) Sagar, University of Sagar.

53. Kapur Tribhuvan, (1985), Drug Epidemic among Indian youth : A study of Drug Addicts, Delhi.
54. Larkin, E.I. (1974), "The treatment of Alcoholism."
55. Munjal, G.C. and Jiloha, R.C., "Drug abuse in Delhi, Department of Psychiatry, G.B. Pant Hospital, New Delhi, 1984".
56. Miller, P.M. (1976), "Behavioural Treatment of Alcoholism".
57. Moss, M.C. and Davies, E.B. (1967), "A survey of Alcoholism in an english country, London".
58. Mecord, W. and Mecord, J. (1960), "Origin of Alcoholism, London".
59. Martin Roth (1979), "Alcohol and Alcoholism, London (The report of a special committee of the Royal College of Psychiatrists)".
60. Mohan, Sharma, Sundram & Mohan Das, "A study of prevalence and pattern of drug abuse in rural Punjab", in Mohan (ed), "Current research in Drug abuse in India".
61. Mohan, D., Sundram, et al., "Drug abuse among school children in current research in drug abuse in India" (ed), op. cit., pp. 110-118.

62. See Mohan's article on "prevalence of drug abuse among university students : Preliminary Report of a multicenter survey in "current research in drug abuse in India" (ed).
63. Mohan, D., Sundram, et al. (1981), paper in "Current research in drug abuse in India", Gemini Printers, Delhi, pp. 18-31.
64. Richard C., Stephens, "Mind attering drugs use, abuses and treatment, Vol. 9, Sage Publications, New Delhi.
65. Robinson, D. (1976), "From drinking of alcoholism". A sociological commentary, London, Wiley (A review and a report on a recent study).
66. Rindesmith, A.R. (1968), "Addiction and opiates", Aldine, Chicago.
67. Sethi, B.B. & Trivedi, J.K. (1979), "Drug abuse in a rural population, Indian Journal of Psychiatry, 21 (3), 211.
68. Sethi, B.B. & Manchanda, R. (1978), "Pattern of drug abuse among male students", Indian Journal of Psychiatry, 20, 166.
69. Sulher-Land, E.H., & S. Gressey, D.R. (1965), "Principles of Giminology, 6th edition, Bombay : Times of India Press".

70. Stark, R. (1975), "Alcoholism and Drug Addiction In Social problem, p. 102, Torno : Random House".
71. Singh, G., (1979), "Drug use among medical students - 1, Prevalence and pattern of user, Indian Journal of Psychiatry. 21 (4) 332.
72. Shamnarayan, T.E. (1978), "A study of drug abuse among college students, Unpublished project".
73. Sharma, Davis, Roy & Roy, A.K. "Hereditary factors in psychoses precipitated by cannabis abuse", paper in 30th IPS conference, "Abstracts", p. 90.
74. Suresh Kumar, Ramchandran & Others, "Psychosocial & Behavioural characteristics of Heroin (brown sugar) abusers", paper in 30th IPS conference, "Abstracts", p. 89.
75. Thacore, V.R., Saxena, R.C. & Kumar, R. (1961), "Epidemiology of drug abuse in Lucknow with special reference to methaquatone, Indian Journal of Pharmacology, 3, 58.
76. U.S. Department of Health, "Education and welfare (1974), Alcohol and Health.
77. Venkoba Rao, A. Sugumar, A & Neelambaracharan, C. (1978), "Drug addiction - A report from Maduri, India. Indian Journal of Psychiatry, 20, 31C.

78. Varma, V.K., Gosh, A., Singh, S. & Wig. N.N. (1977), "Drug abuse among college students in India, Indian Journal of Psychiatry, 19 (1)."
79. Varma, V.K. & Dang, R. (1978), "Non-medical use of drugs amongst school and college students, Indian Journal of Psychiatry, 21, 228.
80. Verghese in Vellore Town : An epidemiological study ; Indian Journal of Psychiatry, 16, 1.
81. Varma, V.K. (1977), "Drug abuse among college students", Indian Journal of Psychiatry, 19, 1.
82. World Health Organisation (1973), "Youth and drugs : The report of study group. W.H.O. Technical Report series No. 516, Geneva : W.H.O."
83. World Health Organisation (1967), "Service for the prevention and treatment of dependence on alcohol and other drugs. W.H.O. Technical Report series No. 363. Geneva : W.H.O.
84. Winslow, J.J. (1974), "Drug use and social integration Indian Journal of the Addictions, 9, 531.
85. Wilkins, R.H. (1974), The Hidden Alcoholic in General Practice, London.
86. Wallgreen, H. and Barry, H. (1970), "Action of Alcohol Volume - 1.
87. World Health Organisation (1977), "Alcohol -

LATEST BOOK, JOURNALS, & REPORTS

LATEST BOOKS, JOURNALS AND REPORTS INCLUDING PH.D.
 DISSERTATIONS, PUBLISHED/UNPUBLISHED - GOVT./WHO/PRIVATE
 ORGANISATIONS' REPORTS (PUBLISHED/MIMEOGRAPHED)

1. Pean Philip, The Social Control of Drugs, Martin Robertson, London, 1974.
2. Goode Erich, Drugs in American Society, Alfred A. Knoopf., New York, 1972.
3. Roy Shibani, Rizvi S.H.M., Incontine Water to Heroin, B.R. Publishing Corporation, 4461, Vivekanand Nagar, Delhi, 1986.
4. Kumar B.V., Tewari R.K., The narcotic Drugs and Psychotropic Substances, laws of India, Konark Publisher Pvt. Ltd., Main Vikar Marg, Delhi, 1990.
5. Blachy, Paul H., Drug Abuse - Data and Debate, Charles C. Thomas, Springfield, Illinois, U.S.A., 1970.
6. Menon, Beena, Drugs - The Evil Addiction, Clarion Books, C-36, Connaught Place, New Delhi, 1989.
7. Chaturvedi Harivansh, Drug Industry ; Social Responsibility and the Multi Nationals, Commonwealth Publishers, New Delhi, 1990.
8. Kapur Tribhuan, Drug Epidemic Among Indian Youth - A study of Drug Addicts, Mittal Publications, Delhi, 1985.

9. Sain Bhim, Jiloha R.C., Sharda Prakashan, Delhi, 1988.
10. Sain Bhim, Alcohol Addiction - A study in Nature and Dimensions of Drinking and Prohibition, H.K. Publishers and Distributors, A-1/11, Shakti Nagar Extension, Delhi, 1989.
11. Dutta P.K. - Drug Control, Eastern Law House, Calcutta and New Delhi, 1990.
12. Mittal Nemisharan, World-Famous Drug Mafias, Family Books Pvt. Ltd., F-2/16, Ansari Road, Daryaganj, New Delhi, 1990.
13. Green helen I., Levy, Mchael H., Drug Misuse ... Human Abuse, Marcel Dekker, Inc. New York and Bsel, 1976.
14. Dusek, Dorothy E. & Girdano Daniel A., Drugs - A factual account (4th edition), Asian Books Pvt. Ltd., New Delhi, 1989.
15. Ghosh S.K., - The Traffic in Narcotics and Drug Addiction, Ashish Publishing House, 1/81, Punjab Bagh, New Delhi, 1987.
16. Gupta S.P. - Statistical Methods, Sulthan Chand Sons, 23, Daryaganj, New Delhi, 1969.
17. Stephens Richard C. - Mind-Altering Drugs, Use, Abuse, and Treatment, Sage Publications, Newbury Park, Beverly Hills London & New Delhi, 1986. (Volume 9 - Law and Criminal Justice Series).

18. David P. Ausubel, Drug Addiction : Physiological, Psychological, & Sociological Aspects, Random House, New York.
19. Imlah Narman - Drugs in Modern Society, Prineelon, New York, Philadelphia, London.
20. Scarpitti Frank R. and Susan Datesman K., Drugs and the Youth Culture, Sage Publication, Beverly Hills, London.
21. Stanton M.D. (1978), "The Family and Drug Misuse, a Bibliography", American Journal of Drug and Alcohol Abuse, 3-4 : 557-570.
22. Villant G.E. (1966), "A twelve year follow up of New York narcotic addicts : 1, The relation of treatment to outcome", American Journal of Psychiatry 122, 7 ; 727-737.
23. Avram Gold Stein, Lewis Aronow and Summer M. Kalman ; Principles of Drug Action (Second Edition), New York, 1974.
24. Johnston, Lloyd D., P.M. O'Malley, and J.G. Bachman (1985), Use of Licit and Illicit Drugs by America's High School Students : 1975-1984, Washington, DC : National Institute on Drug Abuse.
25. Jones-Witters, Patricia and W. Witters (1983) Drugs and Society : A Biological Perspective. Belmont, CA : Wadsworth.
26. Musto, David F. (1973). The American Disease. New Havenm (T : Yale University Press, National Institute on Drub Abuse (1978) Nonresidential Self-Help Organisations and the Drug Abuse Problem : An Exploratory Conference, Washington, DC : Author, (1983) Population Projections. Based on the National Survey on Drug Abuse, 1982, Washington, DC : Author.

JOURNALS - II

1. The Indian Journal of Social Work (January, 1989 - December 1989), "Counselling Perspectives on Drug Abuse, SPARC Addiction Research Core Group, 1989, (Tata Institute of Social Sciences) Issue I 1991, Number 2, April 1991).
2. The Sociological Review February 1988.
3. American Journal of Sociology, Volume 96 Number I July 1990, - Drug Abuse Treatment : A National study of Effectiveness by Robert L. Hubbard, Mary Ellen Marsden. Chapel Hill : University of North Carolina Press 1989, pp. XIX + 213.
4. International Seminar on Drug Problems, Mr. R.L. Handa, I.P.S.
5. Indian Journal of Criminology, January 1987, Vol. I "Tranquillisers as a Social Problem", Jonathan Gabe and Michael Bury, Page No. 320-347, 13th June, 1987. General Practice Research Unit, Institute of Psychiatry, Denmark Hill, London.
6. American Journal of Sociology, U.S.A.
7. American Sociological Review, U.S.A.
8. British Journal of Criminology, U.K.

9. British Journal of Sociology, U.K.
10. Contributions to Indian Sociology, New Delhi.
11. Indian Journal of Criminology (Madras).
12. Sociological Bulletin, Pune.
13. International Review of Modern Sociology, new Delhi.
14. Man in India (Ranchi)
15. Manav (Hindi), Lucknow.
16. Social Welfare, New Delhi.
17. Samaj Kalyan, New Delhi.
18. Probe, Allahabad.
19. The gentlemen, Bombay.
20. American Society of Criminology, Vol. 27, 4th November, 1989, "The Social Organisation of Drug use and Drug dealing among urban gang", Jaffrey Fagan, Columbus O.H. 43212.
21. Feldman, Harvey, W. Jersey and Allen Fields 1985, in the neighbourhood. A strategy for delivering early intervention service to young drug users in their natural environment in Alfreds, Friedman and George Beschner (Eds), Treatment Services, Rock for Adolescent Substance user. Rock Ville, Md National Institute of Drug Abuse.

22. Gandossy, Report P.J. Williams, J. Cohen, 1980, "Drug and Crime" - A survey and analysis of the literature, Washington DC., National Institute of Justice.
23. Gold Stein Paul J. 1985, Journal of Drug issue is : 493-506. "The Drug Violence Nexus - A Tripartite Conceptual Framework."

NEWSPAPER, MAGZINE ETC.

1. The Times of India ;
2. Hindustan Times
3. Economics Times
4. Nav Bharat Times
5. Rajasthan Patrika
6. Rashtradoot
7. Amar Ujala
8. Daily Hindu
9. Financial Express
10. Jansatta
11. Dainik Navjyoti
11. Punjab Kesari
13. Veer Arjun
14. Samachar Jagat

QUESTIONARIES & INTERVIEW SCHEDULE

DRUG ABUSE AMONG STUDENTS IN JAIPUR CITY

(With particular area of Rajasthan University and constituents Colleges Hostels)

BACKGROUND INFORMATION

(Please mark tick (✓) on the correct answer)

Respondent Code No.

1. Sex : Male / Female
2. Age : Years
3. Marital status :
 - i) Married
 - ii) Unmarried
 - iii) Engaged
 - iv) Divorced/Widowed
4. Religion :

Hindu	Christian
Muslim	Jain
Sikh	Others
5. Caste :
 - i) General
 - ii) Scheduled Castes
 - iii) Scheduled Tribes
 - iv) Others
6. Place of Birth :
 - i) Village
 - ii) Town
 - iii) City
 - iv) Metropolitan City
7. Where did you spend last 10 years of your life ?
8. Length of your stay in Jaipur city (Years)

9. Order of your birth in the family : i) First child
ii) Second child
iii) Third child
iv) Forth child
v) Fifth child

10. Whom do you consider to be most affectionate towards you ?

- i) Mother, ii) Father, iii) Grand Parents,
iv) Brothers, v) Sisters, vi) Bhabis

11. What is the form of your family ?

Type :

1. Nuclear (Parents + Unmarried brother and sister)
2. Joint (Parents + Grand Parents + Unmarried brothers/
sisters + Married brothers)

12. Size of the family -

Upto three members

4 to 6 members

7 to 9 members

13. Monthly income of the family -

Rs. 1,000 - 2,000

Rs. 2,001 - 3,000

Rs. 3,001 - 4,000

Rs. 4,001 - and Above

14. Education

Which class are you studying in ?

- | | |
|------------------|-----------------|
| a) Undergraduate | b) Postgraduate |
| i) Pre-degree | i) 1st Year |
| ii) 1st Year | ii) 2nd Year |
| iii) 2nd Year | iii) 3rd Year |
| iv) 3rd Year | iv) 4th Year |
| v) 4th Year | v) 5th Year |
| vi) 5th Year | |

15. What is your course of study ?

1. Professional, 2. Non-professional

- i) (Law, Engineering, Medical)
- ii) (Arts, Science, Social Sciences, Commerce)

16. Mention the type of school/you studied in during last three years before joining the college/university.

- i) Govt. School
- ii) Public/Private School
- iii) Convent/Mission School

17. What was the medium of your education

i) English, ii) Hindi, iii) Others

18. What division/grade did you obtain in your last examination ?

- i) Distinction
- ii) First Division
- iii) Second Division
- iv) Third Division

19. Please tick mark the extra-curricular activities you participate/ participated ?
- i) N.C.C.
 - ii) N.S.S.
 - iii) Sports & Games
 - iv) Other (specify)
20. How do you spend your leisure time ?
21. How much money do you spend on your leisure activities ?
- i) Below Rs. 25/-
 - ii) Rs. 25/- to Rs. 49/-
 - iii) Rs. 50/- to Rs. 74/-
 - iv) Rs. 75/- to Rs. 99/-
 - v) Rs. 100/- to Rs. 124/-
 - vi) Rs. 125/- and above
22. How long have you stayed in this Hostel ?
23. How much money do you spend per month ?
24. Are you getting this money from -
- i) Parents
 - ii) Scholarship
 - iii) Tutions
 - iv) Other sources (including part-time job)

25. Do any of the following persons, smoke, drink or take addictive drugs ?

I. PARENTS :

1. Name of the above
2. Smoke only
3. Drink only
4. Smoke and Drink
5. Take drugs only
6. Drink and taking drugs
7. Smoke and take drugs
8. Smoke, drink and take drugs

II. BROTHERS/SISTERS (SIBLINGS)

1. None of the above
2. Smoke only
3. Drink only
4. Take drugs only
5. Smoke & Drink
6. Drink and take drugs
7. Smoke and take drugs
8. Smoke, drink and take drugs

II. FRIENDS :

1. None of the above
2. Smoke only
3. Drink only
4. Take drugs only
5. Smoke & Drink
6. Drink and take drugs

26. What interest do your parents take in your career ?

- i) Very much
- ii) Normal/satisfactory
- iii) Indifferent

27. How could you describe the relationship between you and the following :

I. BETWEEN YOU AND YOUR FAMILY :

- i) Harmonious ; ii) Hostile ; iii) Indifferent

II. BETWEEN YOUR FATHER AND MOTHER ;

- i) Harmonious ; ii) Hostile ; iii) Indifferent

III BETWEEN YOU AND YOUR BROTHER :

- i) Harmonious ; ii) Hostile ; iii) Indifferent

28. How would you describe your parents control over you ?

- i) Lenient
- ii) Moderately strict
- iii) Very strict

29. Do you take parents advice in facing the problem ?

- i) Never
- ii) Sometimes
- iii) Always

30. In general how after do your parents -

a) SCOLD YOU :

i) Never ; ii) Seldom ; iii) Occassionally ; iv) Frequently

b) BEAT YOU :

i) never ; ii) Seldom ; iii) Occassionally ; iv) Frequently

c) ADVICE YOU :

i) Never ; ii) Seldom ; iii) Occassionally ; iv) Frequently

d) ENCOURAGE YOU :

i) Never ; ii) Seldom ; iii) Occassionally ; iv) Frequently

31. If you use/used drugs you need answer this question

a) Do you use/used drugs ? YES/NO

b) If yes, then

Do your parents know :

i) Smoke YES/NO

ii) Drink YES/NO

iii) Take drugs YES/NO

c0 If yes, then what do your parents ?

i) Never

ii) Seldom

iii) Beat you

iv) Encourage

v) Discourage you

32. Do you know that some of your hostel inmates take drugs ?

YES/NO

33. If yes, what is your opinion about those inmates ?
a) Like ; b) Dislike ; c) Indifferent
34. Mentions the name of drugs used by them ?
1. 4.
2. 5.
3. 6.
35. How often do/did they use them :
a) Less often than a month
b) About ones a month
c) Once a week
d) Several times a week
e) Daily
f) No response
36. Have you ever used any drugs ?
i) Never ; ii) Tried earlier but discontinued ;
iii) Currently using
37. Which of the following substances were/are being used by you.
i) Alcohol (Beer, wine, hard liquor)
ii) Amphetamines (Speed, Dexedrine, Retalin, Methedrine)
iii) Barbiturates
iv) Cannabis (Marijuana, Charas, Bhang, Hashish)
v) Heroin (Brown sugar, smack)
vi) L.S.D.
vii) M.O.T. (Monoxytripramate)

- viii) Opium (Goli)
- ix) Pethidine/Morphine
- x) Painkillers (Asprin, Anaein, Codeine, Aspro)
- xi) Tranquilisers (Equilibrium, Equanil Librium, Calmpose)
- xii) Tobacco (Cigarettes, cigar, pipe, bidi, khaini or surti, gutka)

38. Name the substances which you can not do without ?

- | | |
|----|----|
| 1- | 2. |
| 3. | 4. |

39. Why do/did you use these drugs ?

- 1. As a medicine
- 2. Self confidence
- 3. Friend's pressure
- 4. To satisfy curiosity
- 5. To relieve tension
- 6. To improve study
- 7. To heighten sexual experience
- 8. To increases appetite
- 9. To increase aesthetic awareness
- 10. To gain self confidence
- 11. Another reason.

40. Did you begin with the substance (drg) you are using currently ?

YES/NO

- a) If yes, mention the name of the drug
- b) If no, then specify the reason for its discontinuance-

41. Why did you take the risk of taking the drug ?

- i) To gain first hand experience.
- ii) To experience the effect of drug.
- iii) To gain concentration in studies.
- iv) To overcome excitement
- v) To overcome problems

42. When did you use the substance first ?

- i) During middle schooling
- ii) During secondary schooling
- iii) During undergraduate study
I Year / II Year / III Year
- iv) During post-graduate study
I Year / II Year / III Year
- v) Don't remember

43. Who prompted you to use drug ?

- i) Self curiosity
- ii) Physician
- iii) Parents
- iv) Brother/Sister
- v) Friends
- vi) Off campus acquaintance
- vii) Don't remember

44. How did you feel when drug was used first

- i) Felt excited
- ii) Felt
- iii) Felt like vomiting
- iv) Felt cramping of the body
- v) Felt restive
- vi) Felt very happy
- vii) Felt sleepiness
- viii) Felt sexually excited
- ix) Felt being lost in the world

45. How did you feel on being drugged off ?

- i) Felt remorseful
- ii) Decided to discontinue
- iii) Decided to increase drug intake
- iv) Resolved to decrease the quantity of drug
- v) Gave not thought to it.

46. How do you take the drug ?

- i) Eat it
- ii) Chewing it
- iii) Smoke/Pip/Bidi etc.
- iv) Injected in the body
- v) Take it in (Goli) form
- vi) Take it in other forms.

47. What is your source of getting the drugs ?

- i) Medical shop
- ii) Physician
- iii) Friends
- iv) Parents
- v) Siblings
- vi) Other relatives
- vii) Drug pedlers

48. Indicate the amount of money you spend per month on purchase of different drugs ?

Drug	Amount (in Rupees)
1. Alcohol	
2. Amphetamines	
3. Barbiturates	
4. Cannabis	
5. Heroin	
6. L.S.D.	
7. M.O.T.	
8. Opium	
9. Pethidine	
10. Pain-killers	
11. Tranquilisers	
12. Tobacco (Bidi, cigarettes, gutakas etc)	
13. Marijuana	
14. Morphine	

49. Do you borrow money to satisfy your drug taking need ?

1. Yes, 2. No, 3. Can't say

a) If yes, did feel ashamed of it ?

50. What is the quantity of drug you took/are taking currently ?

Drug	Number per week	Quantity
------	-----------------	----------

- | | | |
|-----|-----------------------------------|--|
| 1. | Alcohol (Beer, wine) | |
| 2. | Amphetamines (Methylamphetamins) | |
| 3. | Barbilurates (Mandrax) | |
| 4. | Cannabis (Charas, hashis, bhang) | |
| 5. | Heroin (Brown sugar, smack) | |
| 6. | L.S.D. (Psychedellies) | |
| 7. | M.O.T. (Monoxytriplamate) | |
| 8. | Opium (Goli) | |
| 9. | Pethidine | |
| 10. | Painkillers (Asprin, Anaein etc.) | |
| 11. | Tranquilisers (Librium, Valium) | |
| 12. | Tobacco (Bidi, Pipe, Cigarettes) | |
| 13. | Marijuana | |
| 14. | Morphine | |

51. how do you like/njoy drug taking ?

a) Alone

b) Friends company

c) According to the situation

52. Did you ever compel/pressirice someone to take drug ?

YES/NO

53. If yes, did you feel repentent about it.?
Yes No Can't say
54. When did you increase the frequency/quantity of drug intake process?
i) In the beginning stage
ii) in the middle of the process
iii) Just recently
55. Give approximate multiple of for the above increase in drug take
i) Double of the first intake.
ii) Triple of the first intake
iii) Four time of the first intake
iv) More than four times.
56. What do you do after taking the drug ?
i) Remain alone
ii) Fall a sleep
iii) Devote more time to study
iv) Listen to Radio/music
v) Visit a restaurant/cinema
vi) Do nothing (remain idle)
viii) Do routine activities as usual
57. Did you ever attempt to give up drug taking ?
i) Never ; ii) Seldom ; iii) Time and again

58. If yes, how did you feel after doing so ?
- i) Felt restless
 - ii) Felt giddy
 - iii) Felt like vomiting
 - iv) Felt stomach cramps
 - v) Felt pain in limbs
 - vi) Felt frustrated
59. Do you think it is easy or otherwise to give up drug taking ?
- i) Easy to give up
 - ii) Very different
 - iii) Not so difficult
 - iv) Impossible
60. What difficulties you which giving up drug taking ?
- i) Lost self control
 - ii) Felt mental tension
 - iii) Felt pain in the body
 - iv) Felt restless
 - v) Failed to behave nicely
 - vi) Felt helpless
 - vii) Avoided social responsibility
 - viii) Others
61. Give the chief (basic) reason for giving up drug taking ?
- i) Felt curiosity satisfied
 - ii) Felt doing so far normal living
 - iii) Difficult avoidability of drug

- iv) Pressure of parents and relations
- v) Pressure of friends
- vi) bitter experience of drug taking

62. What is your attitude towards drugs ?

- i) Favourable
- ii) Infavourable
- iii) Indifferent
- iv) No response

63. How do you perceive the use of drug by students/general public

STUDENTS :

- 1. Dislike
- 2. Like
- 3. Indifferent
- 4. Antisocial
- 5. Having social status
- 6. Can't say

GENERAL PUBLIC

- 1. Like
- 2. Dislike
- 3. Indifferent
- 4. Antisocial
- 5. Having social status
- 6. Can't say

64. What was the result of your resolved ?
1. Discontinue for ever
 2. Discontinue temporary
 3. Decrease the quantity and frequency
 4. Increase the quantity and frequency
65. Give reasons for your abstaining from/discontinue the use of drugs
- a) Not available or no access to the substance.
 - b) Under the influence of parents
 - c) Under the influence of friends
 - d) At risk of social disapproval
 - e) Developing personal dislike for the substance
 - f) At risk of getting accicted to the substance
 - g) At the risk of physical/mental problems.
 - h) Find the substance as being too expensive
 - i) Due to having bad trip experience
66. Give your suggestions for discouraging
- i) Giving up discouraging
 - ii) Social control of drug
 - iii) Regarding the latest way for begalising the use of drugs

*

INTERVIEW SCHEDULE REGARDING SOCIAL PERCEPTION
OF SELECTED RESPONDENTS ABOUT REGULAR/ADDICT USERS

PRELIMINARY INFORMATION

1. Code No. of Drug Users
(Regular/Addict)
2. Respondent Name
3. Age
4. Sex
5. Address
6. Nature of relationship
(how related to coded drug users)
 - i) Parents Male/Female
 - ii) Sibling Male/Female
 - iii) Relations Male/Female
 - iv) Friends Male/Female
 - v) Prefect Male/Female
 - vi) Warden Male/Female
7. Duration of contact with the drug user

Upto 5 years	Upto 5 years
More Less	No change
8. Congitive function/
social functioning
 - a) Ambition/
Aspiration
 - b) Competitive
 - c) unconventional
 - d) Intelligent

e) Honest

f) Religious/Spiritual

g) Another information

- | | | | | |
|-----|-------------------|-----------|-----------|-----------|
| 9. | Productivity | Increased | Decreased | Unchange |
| 10. | Social position | Rise | Fall | No change |
| 11. | Date of interview | | | |

Note : The relevant/necessary information is to be gathered through indirect questions/insinuations/innuendos or close observations of facial expressions actions.

APPENDIX

APPENDIX

TESTS OF SIGNIFICANCE AND GOODNESS OF FIT)

CHI-SQUARE TEST

Various test of significance such as t , F and z are based on the assumptions that the samples were drawn from normally distributed populations, or more accurately that the sample means were normally distributed. Since the testing procedure requires assumption about the type of population or parameters, i.e. population values, these tests are known as 'parametric tests'.

There are, however, many situations in which it is not possible to make rigid assumption about the distribution of the population from which samples are being drawn. This limitation has led to the development of a group of alternative techniques known as non-parametric or distribution free methods. When such tests are used, no assumption about the parameters of the population or populations from which we draw our samples is made. Chi-square test of independence and goodness of fit is a prominent example of the use of non-parametric tests.

Recently the non-parametric tests have become very popular in sociological, psychological and business

research. But the increasing popularity of non-parametric tests should not lead us to form an impression that they are usually superior to the parametric methods. In fact, in situations where para-metric and non-perametric tests both apply, the former are more desirable than the latter.¹

The x^2 test (pronounced as chi-square test) is one of the simplest and most widely used non-parametric tests in statistical work. The x^2 chi-square - a Greek letters) is a quantity and describes the magnitude of the discrepancy between theory and observation. It is defined as :-

$$x^2 = \frac{(O - E)^2}{E}$$

Where O refers to the observed frequencies and E refers to expected frequencies.

To determine the value x^2 , the steps required are :-

- i) calculate the expected frequencies,

1. S.P. Gupta : Statistical Methods, Sultan Chand & Sons, New Delhi Parker, Robert I : Statistics for Business Decision Making.

- ii) take the difference between observed and expected frequencies and obtain the squares of these differences, i.e. obtain the values of $(O - E)^2$
- iii) divide $(O - E)^2$ obtained in step (ii) by the respective expected frequency $(O - E)^2$ and obtain the total. This gives the value of x^2 which can range from zero to infinity. If x^2 is zero, it means that the observed and expected frequencies completely coincide. The greater the discrepancy between the observed and the expected frequencies, the greater shall be the value of x^2 .

The calculated value of x^2 is compared with the table value of x^2 for given degrees of freedom at a certain specified level of significance. If at the started level (generally 5 per cent level is selected) the calculated value of x^2 is more than the table value of x^2 , the difference between theory and observation is considered to be significant, that is, it could not have arisen due to fluctuations of simple sampling. If, on the other hand, the calculated value of x^2 is less than the table value, the difference between theory and observation is not considered significant, i.e., it is regarded as due to fluctuations of simple sampling and hence ignored.

It should be noted that value of x^2 is always positive and its upper limit is infinity. Also since x^2 is derived from observations, it is a static and not a parameter. There is no parameter corresponding to it. The x^2 test is therefore termed non-parametric. It is one of the great advantages of this test that it involves no assumption about the form of the original distributions from which the observations come.

DEGREES OF FREEDOM

While comparing the calculated value of x^2 with the table value we have to determine the degrees of freedom. By degrees of freedom, we mean the number of classes to which values can be assigned arbitrarily or at will without violating the restrictions or limitations placed. For example, if we are to choose any five numbers whose total is hundred (100) we can exercise our independent choice for any four numbers only, the fifth number is fixed by virtue of the total being 100 as it must be equal to 100 minus the total of the four numbers selected. For example, if the four numbers are 20, 35, 15, 10 the fifth number must be $(100 - (20+35+15+10) = 20)$. Thus we were to choose any five numbers we could choose any four only. Our choice was reduced by one because of

one condition placed in the data, i.e., that of total being 100. Thus there was only one restriction (or restraint) on our freedom - our degrees of freedom were only four. If more restrictions are placed our freedom to choose will be still curtailed. For example, if there are 10 classes and we want our frequencies to be distributed in such a manner that the number of cases, the mean and the standard deviation on agree with the original distribution, we have three constraints (restrictions) and so three degrees of freedom are lost. Hence in this case the degrees of freedom will be $10 - 3 = 7$. Thus the number of degrees of freedom is obtained by subtracting from the number of classes the number of degrees of freedom lost in fitting symbolically, the degrees of freedom are denoted by the symbol ν (pronounced nu) or by **d.f.** and are obtained as follows :

$$\nu = n - k$$

Where k refers to the number of independent constraints. We have a constraint or restriction whenever observed or theoretical frequencies are made to agree with one another in some one respect in the operations that lead to the calculation of χ^2 . Thus a constraint is imposed by the condition $f_o = f_e$. In general when we fit a

binomial distribution, the number of degrees of freedom is one less than the number of classes. When we fit a Poisson distribution, the degrees of freedom are 2 less than the number of classes (since we use total frequency and arithmetic mean), and when we fit a normal curve, the number of degrees of freedom is small by 3 than the number of classes (because in the fitting we use total frequency, mean and standard deviation).

In a contingency table the degrees of freedom are calculated in a slightly different manner. The marginal total or frequencies place the limit on our choice of selecting cell frequencies. The cell frequencies of all columns but one ($c-1$) and of all rows but one ($r-1$) can be assigned arbitrarily and so the number of degrees of freedom for all the cell frequencies $(c-1)(r-1)$, where c refers column and r refers to rows. Thus in 2×2 table the degrees of freedom $= (2 - 1)(2 - 1) = 1$. Having filled up one cell in such a table the rest of frequencies automatically follow - there is no choice for them. Similarly in 3×3 contingency table, the number of degrees of freedom is $(3 - 1)(3 - 1) = 4$, and so on. It means only 4 expected frequencies need be computed. The others are obtained by subtraction from normal totals.

The computed value of x^2 is a random variable which takes on different values from sample to sample. In other words just like other test statistics, x^2 has a sampling distribution. It can be shown that for large sample sizes the sampling (probabilities) distribution of x^2 can be closely approximated by the chi-square distribution whose probability function is :

$$f(x^2) = c(x^2)^{(v/2) - 1} e^{-x^2/2}$$

Where $e = 2.7183$

v = number of degrees of freedom

c = a constant depending only on v .

The chi-square distribution has only one parameter, v the number of degrees of freedom and as such this distribution is completely defined by the number of degrees of freedom. There is a different x^2 distribution for each number of degrees of freedom. The distribution is skewed to the right for small degrees of freedom, and as the degrees of freedom increase the curve becomes more and more symmetric and becomes approximately normal for large degrees of freedom. The figure shown below gives the distribution of x^2 for 2, 4 and 8 degrees of freedom. It

is clear from the diagram that as the degrees of freedom increase the curve becomes more and more symmetric. The mean of the χ^2 distribution is equal to the degrees of freedom and its variance is equal to twice the degrees of freedom.

THE χ^2 TEST WHEN THE DEGREES OF FREEDOM EXCEED 30

The table values of χ^2 are available upto 30 degrees of freedom. For degrees of freedom greater than 30, the distribution of χ^2 approximates the normal distribution. Constraints which involve linear equations in the cell frequencies (i.e. equations containing no squares or higher powers of the frequencies) are called linear constraints. For degrees of freedom greater than 30 the approximation is acceptably close. The mean of the distribution of χ^2 is $2v - 1$, and standard deviation is equal to 1. Thus the application of the test is simple, for deviation of $\chi^2 - 2v + 1$ may be interpreted as a normal deviate with unit standard deviation. that is,

$$Z = \frac{\chi^2 - 2v + 1}{1}$$

ALTERNATIVE METHOD OF OBTAINING THE VALUE OF χ^2

In a 2×2 table where the cell frequencies and marginal total are as below :

a	b	(a+b)
c	d	(c+d)
(a+c)	(b+d)	N

N is the total frequency and the larger cross product, the value of x^2 can easily be obtained by the following formula :

$$x^2 = \frac{(ad - bc)^2 N}{(a+c)(b+d)(c+d)(a+b)} \quad \text{or}$$

with Yate's correction

$$x^2 = \frac{(ad - bc - \frac{1}{2} N)^2 N}{(a+c)(b+d)(c+d)(a+b)}$$

CONDITIONS FOR APPLYING x^2 TEST

The following conditions should be satisfied before applying the x^2 tests :

- 1) N must be reasonably large. When N is small the probability given by the x^2 test is too small, with the result.

We have seen that the distribution of x^2 tends to normality as the degrees of freedom increase. However, R.A. Fisher has shown that this tendency is more pronounced for the quantity $2x^2$ than for x^2 , thus for a stated value of v we get a better

approximation to normality by using the distribution of the former quantity. That the χ^2 test might lead to hypothesis being discredited whereas the exact procedure might cause one not to discredit a hypothesis. It is difficult to say what constitutes largeness, but as an arbitrary figure we may say that N should be at least 50, however few the cells.

3. No theoretical cell frequency should be small. Here again it is hard to say what constitutes smallness but 5 should be regarded as the very minimum and 10 is better. In practice data not infrequently contain cell frequencies below these limits. As a rule, the difficulty may be met by amalgamating such cells into a single cell entitled '10 and over'.
3. The constraints must be linear. Constraints which involve linear equations in the cell frequencies (i.e. equations containing no squares or higher powers of the frequencies).

The Yates' correction for continuity is introduced because the theoretical chi-square distribution is

continuous whereas the tabulated values are based on the distribution of discrete x^2 statistic. The correction has the effect of reducing the calculated value of x^2 as compared to the corresponding value without correction.

In a special case of 2 x 2 contingency table the approximation may be improved, and bias arising out of the use of small theoretical frequencies may be reduced, by means of correction proposed by F. Yates. The correction involves the reduction of the deviation of observed from theoretical frequencies which of course reduce the value of x^2 . The working rule for the application of correction is : adjust the observed frequency in each cell of the 2 x 2 table in such a way as to reduce the absolute deviation of the observed from the theoretical frequency for that cell by $\frac{1}{2}$; adjustments for all the cells are to be made without changing the marginal totals. This operation will increase f_o by $\frac{1}{2}$ in each of two cells, and will reduce f_o by $\frac{1}{2}$ in each of two cells. An illustration of this is given below¹ :

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1. For detailed discussion of the chi-square test, please refer to S.P. Gupta : **Statistical Methods**, Sultan Chand & Sons, New Delhi.

Another method of adjustment which gives the same result as the above procedure is :

$$x^2 \text{ (corrected) } = \frac{(O_1 - E_1) - 0.5}{E_1} + \frac{(O_2 - E_2) - 0.5}{E_2} + \frac{(O_k - E_k) - 0.5}{E_k}$$

In general, correction is made only when the number of degrees of freedom or $v = 1$ and N is small. For large samples this yields practically the same result as the uncorrected x^2 . For small samples where each expected frequency is between 5 and 10, it is perhaps best to compare both the corrected and uncorrected values of x^2 . If both values lead to the same conclusion regarding a hypothesis, such as acceptance or rejection at 0.05 level, difficulties are rarely encountered. If they lead to different conclusions, one can either resort to increasing sample sizes or if it is proved impractical, one can employ exact methods of probability involving the multinomial distribution.

GROUPING WHEN INDIVIDUAL FREQUENCIES ARE SMALL

If small theoretical frequencies occur (less than 10 and certainly not less than 5) it is generally possible to overcome the difficulty by grouping two or more classes. In other words, one or more classes with

with theoretical frequencies less than 5 may be combined into a single category before calculating the difference between observed and expected frequencies. With this practice it is important to remember that the number of degrees of freedom is determined with the number of classes after the regrouping. For example, if we start with 12 classes and three of them have small theoretical frequencies, we may pool these classes into one and shall be left with 10 classes to compare (please refer to illustration below).

ILLUSTRATION 1

The following table gives the classification of 100 drug users according to sex and to nature of work. Test whether nature of work is independent of the sex of the drug users worker.

	Skilled Drug User	Un-skilled Drug User
Male	40	20
Female	10	30

SOLUTION :

SOLUTION

Let us take the hypothesis that there is no association between nature of work and the sex of the worker i.e. they are independent.

40	20	60
10	30	40
50	50	100

$$\text{Expection of (AB)} = \left[\frac{(A) \times (B)}{N} \right]$$

$$\text{Exception of (AB)} = \left[\frac{60 \times 50}{100} \right] = 20$$

The table of expected frequency is :

30	30	60
20	20	40
50	50	100

Applying the x^2 test,

O	E	$(O - E)^2$	$\frac{(O - E)^2}{E}$
40	30	100	3.333
10	20	100	5.000
20	30	100	3.333
30	20	100	5.000
			$\frac{(O - E)^2}{E} = 16.666$

$$V = (r - 1) (c - 1) = (2 - 1) (2 - 1) = 1$$

$$\text{For } v = 1 \quad x^2_{0.05} = 3.84$$

The calculated value of x^2 is much greater than the table value, hence the result of the experiment does not support the hypothesis. Nature of work does not seem to be independent of the sex of the drug using worker.

When the alternate method of calculating the value of x^2 is applied, we shall proceed as follows :-

$$x^2 = \frac{(ad - bc)^2 N}{(a+c)(b+d)(c+d)(a+b)}$$

It can be seen that the answer is the same by both the methods.

Actually the x^2 test is the test of badness of fit, since the result of the leads the statistician to conclude either that the fit of a normal distribution to the observed distribution is bad or that the evidence that it is bad is not convincing and, therefore, it may be said to be "good" Grieeim - p. 263.

USES OF CHI-SQUARE TEST

x^2 test is one of the simplest and the most general tests known. It is applicable to a very large number of problems in practice, as a test of independence ; as a test of goodness of fit ; as a test of homogeneity.

1. x^2 test as a test of independence

With the help of x^2 test we can find out whether two or more attributes are associated or not. Suppose we have N observations classified according to some attributes. We may ask whether the attributes are related or independent. Thus we can find out whether age-group or education has some association with the use of drugs. In order to test whether or not the attributes are associated we take the null hypothesis that there is no association between the attributes under study, or, in other words, the two attributes are

independent. If the calculated value of x^2 is less than the table value at a certain level of significance (generally 5 per cent level, we say that the results of the experiment provide no evidence for doubting the hypothesis or, in other words, the hypothesis that the attributes are not associated holds good. On the other hand, if the calculated value of x^2 is greater than the table value at a certain level of significance, we say that the results of the experiment do not support the hypothesis or, in other words, the attributes are associated.

It should be noted that x^2 is not a measure of the degree or form of relationship ; it only tells us whether two principles of classification are or are not significantly related, without reference to any assumptions concerning the form of relationship.

2. x^2 test as a test of goodness to fit*

x^2 test is very popularly known as test of goodness of fit for the reason that it enable us to ascertain how all the theoretical distributions

such as binomial, poisson, normal etc., fit empirical distributions, i.e., those obtained from sample data. When an ideal frequency curve whether normal or some other type is fitted to the data, we are interested in finding out how well this curve fits with the observed facts. A test of the concordance (goodness of fit) of the two can be made just by inspection, but such a test is obviously inadequate precision can be secured by applying the χ^2 test. If the calculated value of χ^2 is less than the table value at a certain level of significance (generally 5 per cent level), the fit is considered to be good, that is, the divergence between the actual and expected frequencies is attributed to fluctuations of simple sampling. On the other hand, if the calculated value of χ^2 is greater than the table value, the fit is considered to be poor, i.e., it cannot be attributed to fluctuations of simple sampling rather it is due to the inadequacy of the theory to fit the observed facts. It should be borne in mind that in repeated sampling too good a fit is just as likely as too bad a fit when the computed χ^2 value too close to zero, we should

spspect the possibility that the two sets of frequencies have been manipulated in order to force them to agree and, therefore, the design of our experiment should be thoroughly checked. (Chou : Statistical Analysis, p. 457).

*(Actually the x^2 test is a test of badness of fit, since the result of the test leads the statistician to conclude either that the fit of a normal distribution to the observed distribution is bad or that the evidence that it is bad is not convincing and, therefore, it may be said to be good." - Griffin :

3. x^2 test as a test of homogeniety

When we say things are homogeneous we mean that they have something in common or they are the same or they are equal. The x^2 test of homogeneity is an extension of the chi-square test of independence. Tests of homogeneity are designed to determine whether two or more independent random samples are drawn from the same population or from different populations. Instead of one sample as we

use with independence problem we shall have now two or more samples. For example, we may be interested in finding out whether or not university students of various levels i.e., under-graduate, post-graduate, Ph.D., feel the same in regard to the prestige or respectability attached to the use of drugs. We shall take the hypothesis that the three samples come from the same population ; that is, the three classifications are homogeneous in so far as the opinion of three different groups of student about the social rating of drug-use is concerned. This also means that there exists no difference in opinion among the three classes of people on the issue.

It should be noted that in both the types of tests, i.e., test of independence and homogeneity, we are concerned with cross-classified data. The same testing statistic used for tests of independence is used for the tests of homogeneity. These two types of tests are, however, different in a number of ways. First, they are associated with different kinds of problem. Tests of

indepdence are concerned with the problem whether one attribute of independence is independent of another, while tests of homogeneity are concerned with whether different samples come from the same population. Secondly, the former involves a single sample taken from one population, but the latter involves two or more independent samples one from each of the possible populations in question.

MISUSE OF CHI-SQUARE TEST

Probably one of the most frequently used statistic is the chi-square. Unfortunately, it is also one of the most frequently misused. It is easy to learn to compute, but its correct application is not so easily learnt.

The most common mistake in the application of the chi-square statistic and yet the most critical for its correct application is the violation of independence between measures of events. This assumption of independence refers to the individual observation or frequencies and means that the occurrence of one event has no effect upon the occurrence of any other event. Another way of stating this meaning of independence is that the probability of each event's occurrence is independent of the probability of occurrence of all other events. In statistical terms we say that the joint probability of two random events is equal to the product of the probabilities of these events.

The chi-square as a test of independence refers to the statistical test of the possibility of a relationship between two variable. This is often called a test of association, the question tested is whether the

frequencies observed of one category are contingent upon another category. For example, is the number of "yes" answer to some question contingent upon the age of the respondent ?

Some other sources of errors in the application of x^2 test as revealed in a survey of research papers published in the journal of experimental psychology during the years 1944-46 are :-

- i) Small theoretical frequencies.
- ii) Neglect of frequencies of non-occurrence.
- iii) Failure to equalize the sum of observed frequencies and the sum of the theoretical frequencies.
- iv) Indeterminate theoretical frequencies.
- v) Incorrect or questionable categorizing.
- vi) Use of non-frequency data.
- vii) Incorrect determination of the number of degrees of freedom.
- viii) Incorrect computations.

The number of applications of chi-square test does not seem to be increasing but the number of misuses of x^2 has become surprisingly large. A lesson can be drawn from the findings of the **lewis and Burke article**. You cannot simply use a statistic because you know how to calculate it ; you must understand and rationale behind

its development and the limitations on its application imposed by the assumptions underlying it.

LIMITATIONS ON THE USE OF χ^2 TEST

χ^2 test is very widely used in practice. However, in order to avoid the misapplication of the test its following limitations should be kept in mind.

1. Frequencies of non-occurrences should not be omitted for binominal or multinominal events. For example, if 5 drugs were tried out of 5 separate groups of 200 patients each, the number of cures per drug might be shown in one-way table as follows :-

DATA FOR FIVE DRUGS

	<u>Drugs</u>					
	1	2	3	4	5	Total
Number cured	80	120	40	60	20	320

However, χ^2 test should not be applied to these data until the alternative outcome (i.e. "not cured") is represented in the table.

2. The formula presented in this chapter is not appropriate for cases in which repeated measurements on the same or matched groups are represented in one table. When data from questionnaires and similar devices are analysed, the reader should be careful that he does not set-up the tables incorrectly. For example, it may seem reasonable to set up a table as follows :-

	Agree	Neutral	Disagree	Total
Item x	140	190	170	500
Item y	180	150	170	500

However χ^2 contingency test should not be performed on the basis of this table, since it is not really a contingency table because each student is classified twice in the table.

MAPS, CHARTS, GRAPHS AND PHOTOGRAPHS
